Maternal and Child Health Services
Title V Block Grant

State Narrative for Nebraska

Application for 2009
Annual Report for 2007

Document Generation Date: Monday, September 22, 2008

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and Certifications, signed by the CEO, Nebraska Department of Health and Human Services (DHHS), are maintained in the administrative files for Nebraska Title V/MCH Block Grant located in DHHS, Division of Public Health, Lifespan Health Services, Planning & Support. The documents may be inspected by contacting the Title V/MCH Grant Administrator, (402) 471-0197 during regular business hours Monday-Friday, 8:00 a.m.-5:00 p.m. Central Standard Time, or sending a written request to Nebraska Department of Health and Human Services, Division of Public Health, Lifespan Health Services, Planning & Support, P.O. Box 95026, Lincoln, Nebraska 68509-5026.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

A 50-member stakeholder group first organized in 2003 to bring a public perspective to the five-year needs assessment process. Representation was diverse and included consumers, state legislative from various settings including local health departments, community action agencies, hospital, and academia. Participants represented rural and urban, and included racial/ethnic minority populations of Native Americans, African Americans, and Hispanics. The group met during 2003 - March 2005 when the priorities were established. In 2005, five work groups reviewed data of subpopulations, each meeting three times to identify and present significant problem statements for the large group prioritization meeting in March. Group consensus was achieved. Data sheets are posted at http://www.hhs.state.ne.us/fah/RFP.htm.

The priorities established through this mechanism of public input were used to guide funding decisions for state- and community-level funding obligated in June and August 2005 for the fiscal beginning October 1. In addition, members of the stakeholder group will be invited to additional meetings planned by the Office of Family Health beginning in Fall 2005 to expand public input to include strategy development centered on the priorities. /2007/ Strategic planning was postponed to Fall 2006. The stakeholder group from the needs assessment will reconvene then, and additional public input will be sought as warranted by the priorities. The Family Health web site also includes a link for public input into the application each year. //2007//

/2008/ Stakeholders were convened in September 2006 to launch Nebraska's MCH/CSHCN Strategic Planning process. Subsequently, three work groups were formed early in 2007. This planning process continues to be an important conduit for gathering public input on priority strategies for addressing the needs of Nebraska's MCH and CSHCN populations. In addition, the Nebraska Health and Human Services web site included a link on the Office of Family Health

home page for provision of public comments.//2008//

/2009/ The outcomes from the three stakeholder work groups whose problem analysis and strategy development was completed in late 2007 were instrumental in shaping the direction of the next three-year funding cycle FY 2009-2011. A Public Notice seeking input on DHHS' application to the federal government for Title V/Maternal Child Health Block Grant funds for the period of October 1, 2008 - September 30, 2009 was published in the Lincoln Journal Star, a daily newspaper with statewide coverage. A brief written document entitled "Guidelines for Input" were available upon request by calling toll-free (800) 801-1122, and continue to be available on the DHHS web site http://www.dhhs.ne.gov/LifespanHealth/planning/. No comments were submitted. //2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

There have been no changes to Nebraska's ten priority needs in the past year. Although, there have been several activities that relate to the needs assessment process. The first is the capacity building activities of local MCH assessments and the second is an action planning effort to initially address three of the ten priorities.

The local assessment activities have been funded through the block grant with the intent of building core public health capacity around assessment, to increase the ability of local health departments (LHD) to partner and collaborate with maternal and child health community locally and at the state level, and to build local data/expertise into the 2010 needs assessment process. To date nine local health departments are involved in the MCH assessment process with varying degrees of success. It is still unclear if/how local data will be gleaned for the statewide process. However, the ability of the LHD's to effectively participate in the up-coming assessment has been enhanced.

Nebraska kicked off strategic planning activities around the ten priority needs in September, 2006 with a technical assistance consultation from Family Health Outcomes Project (FHOP) contractors/University of California, San Francisco. The event pulled together over 100 stakeholders to introduce the methods and invite participation into small work groups. Based on stakeholder input, staff time/resources, and other activities taking place within the agency three priorities were selected to form workgroups

1. Reduce the rates of overweight women, youth, and children by increasing participation in sufficient physical activity and improving nutrition.
2. Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy.
3. Build capacity of Title V programs for Children with Special Health Care

Needs to provide transition medical and dental clinics for youth with special health care needs 14-21 years.)

All three workgroups have reviewed the current literature and updated needs assessment data to thoroughly analyze the problem/need. They have produced problem analysis diagrams and are currently transitioning in to logic model work. The end product will be a collaborative action plan. Additional, workgroups may then form around infant mortality and intentional injury.

Finally, over the upcoming year staff will begin to establish work plan for the 2010 needs assessment.

/2009/ the following summary was omitted in the past.

In 2004, staff collected and analyzed data from over 400 Maternal and Child Health Indicators. Data was analyzed by trends, disparities, and comparisons with national and HP2010 benchmarks. The Needs Assessment Committee (NAC) then formed and followed a process set forth by University of North Carolina, Program Planning and Monitoring Self-Instructional Manual, "Assessment of Health Status Problems" and described in the University of California at San Francisco Family Health Outcome Project (FHOP) "Developing an Effective MCH Planning Process: A Guide for Local MCH Programs". The steps followed by the NAC were:

1) Set the Objectives and Process of Prioritization,

2) Select Prioritization Criteria,
3) Develop Criteria Rating Scales,
4) Determine Weights for Each Criterion,
5) Convene workgroups,
6) Workgroups review data and identify problems/needs
7) Presentation of identified problems and data summary from all workgroups to the larger planning committee,
8) Agreement on the final problem list to be prioritized,
9) Use Weighted Criteria to Score Problems,
10) Sum Participant's Scores/Rank Problems,
11) Discuss and Confirm Ranked Results

This process resulted in the following 10 priority needs:

1. Reduce the rates of overweight women, youth, and children by increasing participation in sufficient physical activity and improving nutrition.
2. Reduce the percent of women of child-bearing age, particularly pregnant and post-partum women, and adolescents who use tobacco and reduce the percent of infants, children and youth exposed to second hand smoke.
3. Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy.
4. Reduce the rates of hospitalizations and deaths due to unintentional injuries for children and youth.
5. Reduce the number and rates of child abuse, neglect, and intentional injuries of children.
6. Reduce the rates of infant mortality, especially racial/ethnic disparities.
7. Reduce alcohol use among youth.
8. Increase capacity of community-based medical home providers to detect and refer for treatment women, children, and youth with emotional and behavioral health conditions.
9. Increase capacity of Title V Programs for Children with Special Health Care Needs to serve increased numbers of children meeting medical and financial eligibility criteria and who are uninsured or underinsured.
10. Build capacity of Title V programs for Children with Special Health Care Needs to provide transition medical and dental clinics for youth with special health

Staff continued to assess priorities number one, three, and ten through problem analysis and logic model work with stakeholders (the report is attached). Assessment and analysis of number six is on-going it is probable that staff will look deeper into this priority in 2009. There are no changes to report in the 10 identified needs. An internal committee will form in 2009 to begin on the 2010 Needs Assessment. //2009//

An attachment is included in this section.

III. State Overview

A. Overview

Principal characteristics of Nebraska important to understanding the health needs of the entire state's population.

a. Large geographic area

Nebraska is located in the east-central area of the Great Plains midway between New York and San Francisco. Nebraska is generally rectangular in shape with a protruding area in the northwest corner called the Panhandle. The Missouri River bounds the eastern border between Nebraska and Iowa. Missouri, Kansas, Colorado, Wyoming and South Dakota surround Nebraska on the other borders. The State measures 387 miles across, including the western panhandle. The diagonal from northwest to southeast measures 459 miles, and the southwest-northeast diagonal is 285 miles. The state's area is 77,227 square miles, almost 20% larger than all of New England.

Nebraska's large land expanse creates unique health service delivery issues. In rural counties, about 18% of the population are 65 and over, and in 37 counties, the number of persons over age 65 exceeds 20%. This trend has important implications for the delivery of health and medical services because an older population needs more services

Nebraska's population centers are Omaha, Lincoln and several smaller cities scattered along the Platte River and Interstate 80 (which together bisect the state from east to west). Only Omaha and Lincoln (60 miles apart) represent Metropolitan Statistical Areas (MSAs) larger than 50,000 population.

b. Urban and rural

The total population of NE is projected to grow 11% by 2020. Although Nebraska's total population has grown considerably during the 1990s, many small rural counties that are not near a regional economic or health center continue to decrease in size. Most of the decrease in these counties resulted from out-migration of the younger population (18 to 45 years). Smaller population bases make it more difficult to recruit and retain physicians and other health care professionals. A small population base also makes it more difficult to operate institutional services, such as hospitals, and finance other types of services such as mental health, public health, emergency medical services, and long-term care services.

Nebraska's geography shows the state to be a primarily rural and sparsely populated state by national standards, with 32 out of 93 counties as frontier counties (6 or fewer persons per square mile). In contrast, approximately 50% of the state's citizens reside in the population centers of Lincoln and Omaha in the eastern part of the state. The urbanization of Douglas and Sarpy County (Omaha), and Lancaster County (Lincoln) is represented by an average population increase of over 10% between 1990 and 1998.

c. Increasing diversity

Another source of change is Nebraska's rapidly increasing diversity in a state previously regarded as homogeneous. Nebraska currently has its highest percentage of foreign-born residents since the 1870's. Minority populations are growing rapidly in both urban and rural parts of Nebraska. According to the US Census, the state's minority population grew by 23% between 1980 and 1990, and racial/ethnic minorities were found in every Nebraska County. From 1990 to 2000, the minority population rose by 83.5% (from 118,162 to 216,769) and now constitutes 12.7% of the total population while the white population increased by 2.2%. Most of this increase in minorities is Hispanic, whose numbers increased 255%, 40% of the state's overall population increase. However, they are not alone. Nebraska may have one of the largest Sudanese communities in the country. Numbers of Sudanese, Somalian, Bosnian and Vietnamese residents have jumped over the past decade.

In general, the minority population tends to be younger, have lower incomes, higher poverty, and less insurance coverage. They are also more likely to be employed in high-risk occupations such as meat packing plants and farm labor. As a result, these population groups often experience difficulty gaining timely access to health and medical services. Even when services are available, language and cultural barriers prevent effective utilization of these services. There is a need to optimize these services for minority populations using culturally sensitive tools.

Nebraska's vision of healthy individuals, families and communities can only occur if racial and ethnic minority populations have equal opportunities for good health. To bridge the gap between the wide disparities in the health status of racial/ethnic minorities and the white population, it is essential to address the high risk factor prevalence, the major barriers that limit access to high quality health care services, and the need to develop effective local public health services across the state.

(1) Immigration
(a) Hispanic origin
The largest minority group in the state is the Hispanic American population which experienced the most dramatic increase by more than doubling from 37,200 in 1990 to 106,918 in 2003 (a 187% increase) according to the U.S. Census estimates. Hispanic Americans now comprise 6.1% of the state's population. Douglas County, in 2000, had a Hispanic population of 30,928 people. Not surprisingly, these are the highest numbers in the state.
/2007/Hispanic American population which experienced the most dramatic increase by more than tripling from 37,200 in 1990 to 119,975 in 2004 (a 222.5% increase) according to the U.S. Census estimates. Hispanic Americans now comprise 6.8% of the state's population.//2007//

/2008/Hispanic American population which experienced the most dramatic increase by more than tripling from 37,200 in 1990 to 132,371 in 2006 (a 256% increase) according to the U.S. Census estimates. Hispanic Americans now comprise 7.4% of the state's population.//2008//

/2009/Hispanic American population which experienced the most dramatic increase by more than tripling from 37,200 in 1990 to 140,432 in 2007 (a 277% increase) according to the U.S. Census estimates. Hispanic Americans now comprise 7.9% of the state's population.//2009//

The Hispanic American population is expected to increase considerably by 2025. It is estimated that the number of Hispanic Americans in the state will reach 145,000 by 2025, an increase of 36% of the current population estimate. With the availability of employment, the Hispanic population in the central and western part of Nebraska has increased considerably. According to the U.S. Census, Dakota, Dawson, Colfax, Scotts Bluff, Hall, and Morrill counties have a Hispanic population greater than ten percent.

(b) Asian and Pacific Islander
Nebraska's Asian and Pacific Islander (API) grew from a population in 1990 of 12,629 to 29,058 in 2003, according to the U.S. Census Bureau estimates. The Asian/Pacific Islander population is expected to increase considerably by 2025. The Census Bureau estimates that this population will reach 40,000 people, an increase of 38%.
/2007/Nebraska's Asian and Pacific Islander (API) grew from a population in 1990 of 12,629 to 27,922 in 2004, according to the U.S. Census Bureau estimates.//2007//

/2008/Nebraska's Asian and Pacific Islander (API) grew from a population in 1990 of 12,629 to 33,890 in 2006, according to the U.S. Census Bureau estimates.//2008//

/2009/Nebraska's Asian and Pacific Islander (API) grew from a population in 1990 of 12,629 to 36,767in 2007, according to the U.S. Census Bureau estimates.//2009//

(2) Native American
The Native American population in Nebraska grew by 15.7%, from 12,874 in 1990 to 16,298 in 2003, according to the U.S. Census estimates. Native Americans currently comprise 0.9% of Nebraska's total population. Thurston County, home of the Omaha and Winnebago Tribes, ranks number 26 in the U.S. for percentage Native American. Almost half of the county's population is Native American (52%). Four federally recognized Native American tribes are headquartered in Nebraska, the Santee Sioux, Omaha, Winnebago, and Ponca. The Native American population is expected to increase considerably by 2025. Nebraska's Native American population will increase to 25,000 people, an increase of 53%.
/2007/The Native American population in Nebraska grew by 28.6%, from 12,874 in 1990 to 16,562 in 2004, according to the U.S. Census estimates.//2007//

/2008/The Native American population in Nebraska grew by 58%, from 12,874 in 1990 to 20,344 in 2006, according to the U.S. Census estimates.//2008//

/2009/The Native American population in Nebraska grew by 62%, from 12,874 in 1990 to 20,846 in 2007, according to the U.S. Census estimates.//2009//

Though many of Nebraska's Native Americans live on reservations, the majority does not. The urban areas of Omaha and Lincoln account for more than 33% of the state's Native American population, although they make up only a small proportion of these counties' total populations. A sizable group also exists in the northwestern part of NE adjoining the Pine Ridge Reservation in South Dakota. Among the state's reservations, the Winnebago and Omaha reservations in Thurston County account for 22% of Nebraska's Native American population. An additional 3% reside at the Santee Sioux Indian Reservation in Knox County. The Iowa and the Sac and Fox Indian Reservations on the Nebraska-Kansas border account for about 1% of Nebraska's Native American's total population.

(3) African American
African Americans make up 4.0% of the Nebraska population. This population grew from 58,047 in 1990 to 68,541 in 2000, an 18.1% increase. The African American population is expected to increase considerably by 2025, with growth projected at 63% (to 109,000 people). Almost 90% of Nebraska's African American population are located in the most populous counties (Douglas, Sarpy and Lancaster). This growth is fueled by a large number of African immigrants, particularly from Sudan and Somalia; Nebraska may have one of largest Sudanese communities in the country.

/2007/African Americans make up 4.3% of the Nebraska population. This population grew from 58,047 in 1990 to 74,815 in 2004, an 28.9% increase.//2007//

/2008/African Americans make up 4.7% of the Nebraska population. This population grew from 58,047 in 1990 to 83,557 in 2004, an 43.9% increase.//2008//

/2009/African Americans make up 4.8% of the Nebraska population. This population grew from 58,047 in 1990 to 84,853 in 2004, an 46.2% increase.//2009//

(4) Minority Health Professionals
Cultural differences can and do present major barriers to effective health care intervention. This is especially true when health practitioners overlook, misinterpret, stereotype, or otherwise mishandle their encounters with those who might be viewed as different from them as they do their assessment, intervention, and evaluation. Health care professionals' lack of knowledge about health beliefs and practices of culturally diverse groups and problems in intercultural communication has led to significant challenges in the provision of health care services to multicultural population groups. The cultural diversity of the health care workforce itself can present problems that can disrupt the provision of services because of competing cultural values,

beliefs, norms, and health practices in conflict with the traditional Western medical model.

While Nebraska has become an increasingly diverse state, its medical practitioners have not. In 2002, only about 1.2% of Nebraska physicians was African American, although this group makes up 4% of the state's population. This is less than the U.S. average; approximately 4% of all US physicians are African American. Only six Native American physicians practice in NE (0.2% of all physicians) yet this minority group makes up 0.9% of the population.

People of Hispanic origin comprise 6.1% of the state's population and are the fastest growing population group, but account for only 1.3% of Nebraska physicians. Asian Americans are well represented in the physician population. This group makes up only 1.7% of the population of the state, but accounts for 5.3% of physicians.

Additional barriers of receipt of health care were identified for racial and ethnic minority women in Nebraska. One-third of Asian American women (34%) and 12% of Hispanic women reported that language "always," "nearly always," or "sometimes" kept them from getting needed health care, according to a Nebraska Minority Behavioral Risk Factor Survey (NMBRFS).

Respondents to the NMBRFS were asked whether or not they felt racial or ethnic origin is a barrier to receiving health care services in their county. Nearly half of African American women (45%), 40% of Native American and 38% of Hispanic women "strongly agreed" or "agreed" that race or ethnic origin is a barrier. More than one-fourth (28%) of Asian American women expressed agreement with this statement.

(5) Racial and ethnic health disparities
As in other states, Nebraska's minority population has many health disparities. For example, according to an September 2003 report from the NHHSS Office of Minority Health, life expectancy for a Nebraska woman who is white is almost six years longer than for a Nebraska woman who is African American and more than ten years longer for a Nebraska woman who is Native American. African Americans have the highest rates of low-weight births and infant deaths in Nebraska. Native Americans in the state are five times more likely to die of diabetes-related causes than white persons. The CDC's "Women and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality" showed that Nebraska has one of the highest heart disease death rates in the country for African American and Native American women.

d. Aging population
Another significant trend is the aging of the state's population. In 2000, the percentage of the population aged 65 and older was 13.6%, compared to the national average of 12.4%. The total number of Nebraskans over age 65 increased by 4.1%, or by 9,127 individuals, from 1990 to 2000. Nebraska ranks 11th in the nation for percentage of population 65 years and over, however NE ranks only 44th in the nation for percentage change from 1990 to 2000. The population over 65 is projected to grow 48% by 2020. Nebraska ranks 6th in the nation for percentage of the population aged 85 years and over at 2.0%. This is a slight increase from 1990 (1.9%). The total number of people aged 85 and over increased by 4,751 individuals, or by 16.3%. NE ranks 50th in the nation for percentage change from 1990 to 2000.

In rural counties (those with populations of less than 20,000 people) about 18% of the population is 65 and over and in 37 counties the number of persons over age 65 exceeds 20%. Hooker County, Nebraska, ranks 2nd of all U.S. counties for percentage of population over 85 years of age at 6.3%. Nebraska has 17 counties (18%) of its counties in the top 100 of all U.S. counties for percentage of population over 85 years of age. The median age of Nebraskans increased from 33.0 in 1990 to 35.3 in 2000.

This trend has important implications for the delivery of health and medical services because an older population needs more services. However, a shrinking total population base reduces the number of people in the service area. The net result is that fewer health and medical services are

available to meet the needs of the population. These inadequate services are further compounded by the lack of public transportation services in most rural areas of the state. As Nebraska struggles to maintain health care delivery in rural areas, services for older adults become increasingly fragmented and challenging.

e. Special populations
(1) Incarcerated
In Nebraska the average number of women incarcerated is 254. Using national estimates, 63% of incarcerated women have at least one minor child, and approximately 40% have more than one child under age 18. Nationally, 2.1% of the nation's children had a parent in State or Federal prison. African American children were nearly 9 times more likely to have a parent in prison than white children. Hispanic children were 3 times as likely as white children to have an inmate parent. The number of children with a mother in prison nearly doubled since 1991, while the number of children with a father in prison grew by 58% during this period.

/2008// According to Nebraska Department of Corrections there were 418 incarcerated women in 2006, 9.6% of those incarcerated were women which is higher than the national rate of 7.1% (2002). According to the US Department of Justice 70% of incarcerated women has children under the age of 18, and 2.8% of the nation's children had a parent in State of Federal prison in 2000. The Department of Justice estimates the 85% of the female correction population are being supervised in the community.//2008//

/2009/ According to Nebraska Department of Corrections there were 382 incarcerated women in 2007, 8.7% of those incarcerated were women which is lower than the national rate of 12.8% (2007). //2009//

(2) Homeless
The Nebraska Homeless Assistance Program (NHAP) makes funds available to nonprofit organizations through grant awards in order to serve the needs of people who are homeless and near homeless in the state. According to NHAP data, 20,307 people were homeless in Nebraska during the grant year July 2003 to June 2004 and 31,024 people were near homeless during this same time period. These figures include 12% homeless/8% near homeless unaccompanied women, 4% homeless/2% near homeless unaccompanied youth, and 39% homeless/54% near homeless single parent families. During the grant year, Hispanic or Latino persons represented 17 % of persons who were homeless and 11% of those who were near homeless. This year, during the first six months of the grant cycle (July 1, 2004-December 31, 2004), the same agencies and programs assisted 24,099 persons who were homeless and 34,826 who were at imminent risk of homelessness. Both figures exceed those assisted in each category during the prior grant cycle. It is important to note that the data is limited to numbers provided by monthly NHAP Reports received from NHAP programs statewide.

/2008/ According to NHAP data, 34,143 people were homeless in Nebraska during the grant year July 2005 to June 2006 and 54,064 people were near homeless during this same time period of which 22% homeless/11.3% near homeless unaccompanied women, and 2.3% homeless/1.7% near homeless unaccompanied youth. During the grant year, Hispanic or Latino persons represented 14.5 % of persons who were homeless and 15.9% of those who were near homeless. //2008//

/2009/According to NHAP data, 23,743 people were homeless in Nebraska during the grant year July 2006 to June 2007 and 32,122 people were near homeless during this same time period of which 22% homeless/11.3% near homeless people were near homeless during this same time period of which 22.6% homeless/10.9% near homeless unaccompanied women, and 2.1% homeless/1.8% near homeless unaccompanied youth. During the grant year, Hispanic or Latino persons represented 16.2 % of persons who were homeless and 17.4% of those who were near homeless. The overall number of persons homeless or near homeless is a significant decline due to the full implementation of a statewide computer

tracking system which represents an unduplicated count compared to a hand count in previous years were individuals and families were potentially seen in multiple agencies across the state. //2009//

f. Rural poverty
Five of the nation's 12 poorest counties in 2002 were in Nebraska (US Dept. of Commerce). Loup County ranked as the nation's second poorest (per-capita income of $9,281 vs. national per-capita income of $30,906).

2. Agency's current priorities and initiatives with Title V programs' roles and responsibilities.

A description of the Agency's priorities and initiatives first requires an understanding of changing organizational structure. During FFY 2004, administrative changes at the Department head level has an impact on the Office of Family Health. In January 2004, the Governor appointed the Department's Director, Ron Ross, to be the State's new Treasurer, filling a vacancy created through a resignation. A new Department Director was chosen, Nancy Montanez. Ms. Montanez, assuming leadership in a time of major reforms chose to assign line authority for the Health Services branch of the Department to the Chief Medical Officer, Dr. Richard Raymond. This assignment, executed through a Memorandum of Understanding, gave Dr. Raymond full authority and responsibility for programs and activities carried out in this branch, which includes the Office of Family Health and administration of the Title V/MCH Block Grant.

Early in FFY2005, further organizational changes occurred, with Dr. Raymond being named Director of the Department of Health and Human Services Regulation and Licensure. Being a physician, his role as Chief Medical Officer was subsumed into his new title and role. This change more closely aligned the Office of Family Health and Nebraska's Title V administrative activities with HHS Regulation and Li censure. At the same time, a Memorandum of Understanding placed the Office of Aging and Disability Services and Nebraska's Title V/CSHCN Program in the Department of Health and Human Services Finance and Support.

During the 2005 legislative session, LB 301 was passed and signed into law, making the organizational placement of Health Services, including the Office of Family Health, in HHS Regulation and Licensure a statutory placement, effective July 1, 2005. /2007/ Finally, LB 994 was signed into law in 2006, also making the placement of the Office of Aging and Disability Services in the Department of Health and Human Services Regulation and Licensure a statutorily mandated placement.//2007//

/2008/ During the 2007 legislative session, LB 296 was passed and signed into law by the Governor. This bill regorganizes the three agencies that formerly formed the Health and Human Services System into one agency: the Department of Health and Human Services. This new structure went into effect July 1, 2007. The new single agency is headed by a Chief Executive Officer. The Department has six divisions: Public Health, Behavioral Health, Children and Family Services, Developmental Disabilities, Medicaid and Long Term Care, and Veterans Homes. Title V/MCH functions are now located in the Division of Public Health. Title V/CSHCN functions are within the Division of Medicaid and Longterm Care, Safety and Independence Supports Unit. The Division of Public Health has completed the next level of reorganization. Of note to this application is the combination of the Office of Family Health and the Office of Women's Health, forming Lifespan Health Services. //2008//

So though Title V/MCH and Title V/CSHCN are still both within the Nebraska Health and Human Services System, they are now in different agencies, with different directors and differing agency priorities and initiatives./2008/ Title V/MCH and Title V/CSHCN are now within the same agency, though in different divisions.//2008//

In March 2005, HHS Regulation and Licensure identified its 2-year priorities to be: 1) make better use of technology (credentialing processes, health data storage/tracking, etc.); 2) marketing of public health; 3) sound fiscal management; 4) develop and use agency level performance measures; and 5) develop a new immunization registry. The Office of Family Health's Immunization Program is taking the lead for the immunization registry, and the Office is or will be involved in varying degrees with the other 4 priority areas. For instance, a fiscal management work group has been formed, and the Title V Federal Aid Administrator is a member of that group. This participation will facilitate the incorporation of block grant administration issues into the overall efforts of the agency. Working groups and action plans are still to be developed for the other priorities./2008/ The new divisions within the Department of Health and Human Services have just begun work on a strategic plan, including priority outcomes and performance measures. //2008//

/2009/ The Division of Public Health has established five priority areas: wellness, eliminating disparities, data capacity, effective public education and use of the media, and budget transperency.//2009//

Overlaying these established agency priorities are a number of issues that emerged in FFY 2004 and continue to be of importance to the Health and Human Services System, including HHS R&L and the Office of Family Health. Child Protection Reform was initiated with the passage of LB 1089 in April 2004. This funding bill allocated $5.5 million for 120 new protection and safety workers, and another $350,000 for case coordinators. Additional funds were also made available for enhancements of the Criminal Justice Information System and other related activities. Then, during the 2005 legislative session, LB 264 was passed, which adds secondary prevention as a social service that may be provided on behalf of recipients under the Social Security Act. In addition, $200,000 per year was appropriated specifically for home visitation services.

The Office of Family Health is actively partnering with NE HHS Protection and Safety staff in addressing issues of child abuse prevention. Currently underway is the development of a child abuse prevention plan, described in more detail in Section IV B, State Priorities./2008/The Child Abuse Prevention Plan was released in August 2006, and Lifespan Health Services continues to work with Protection and Safety and the Nebraska Children and Families Foundation in its implementation.//2008//

Also enacted in 2004 was enabling legislation for mental health reform. This law established the Behavioral Health Division within HHS and created a State Behavioral Health Council. The focus of this system reform effort has been to ensure statewide access to behavioral health services; ensure high quality behavioral health services; ensure cost-effective services; and ensure public safety and the health and safety of persons with behavioral health disorders. The immediate goal of the reform initiative has been the movement of behavioral health from institutional care to community-based services for persons with chronic and severe mental health disorders. In FFY 2005, the Nebraska Health and Human Services System has had the opportunity to do related work specific to children's mental health. Nebraska is the recipient of a 5-year, $750,000/year State Infrastructure Grant (SIG), awarded by SAMHSA, which is focusing on enhancing and building capacity for children's mental health services. Both the Offices of Family Health and Home and Community Based Services for Aged and Physically Disabled (formerly Aging and Disability Services) have been actively involved in early activities of the SIG grant through participation in an internal stakeholders group.

/2007/ During FY 2006, SIG activities included the development of recommendations specific to early childhood mental health. The Nebraska Title V/MCH Director was active in the work group developing these recommendations, and provided a direct link to and assured coordination with Nebraska's perinatal depression screening project. The Nebraska Title V/MCH Director continues to participate as part of the SIG project management team, assuring ongoing coordination with public health initiatives. //2007//

Medicaid reform is the priority for HHS Home and Community Services Division. Nebraska has initiated Medicaid reform efforts in order to assess the current program and plan for the future. Legislation was passed (LB 709) that established the requirements for a Medicaid reform plan. This law requires that a plan be developed by December 1, 2005. As required by the law, the Governor and the chairperson of the Health and Human Services Committee have each designated a person to be responsible for the development of the plan. The Governor's designee is the Director of Health and Human Services Finance and Support; the Legislature's designee is the General Counsel of the Nebraska Legislature's Health and Human Services Committee. A Governor-appointed 10-person council will advise the process, and the Health and Human Services System will provide the staffing. The Title V/CSHCN Director is chairing a work team (Disabled Adults) and the Title V/MCH Director is a member of another work team (Children and Pregnant Women).

/2007/ As required by LB 790, the Nebraska Medicaid Reform Plan was presented to the Governor and the Legislature on December 1, 2005. This plan included a wide range of findings, recommendations and strategies. The plan made it clear that no major changes in eligibility or benefits were being recommended at this time. The recommendations of most significance to the MCH and CSHCN populations were: establishing a separate SCHIP program (currently a Medicaid expansion); requiring a contribution from parents with incomes in excess of 150% of poverty for children participating in the Katie Beckett program, Aged and Disabled Waiver program, Children's Developmental Disability Waiver, the Early Intervention Waiver, and the State Ward Program; and including as a covered services, a nurse home visitation program for high-risk pregnant teens. Other recommendations, such as those related to prescription drugs, will have impacts as well, if/when implemented. Work groups are currently studying these recommendations in greater detail. //2007//

/2008/ Understanding the situation states everywhere are facing with regards to providing services to low income individuals, Nebraska Health & Human Services has chosen Medicaid reform as the state's priority. A work group for children with special health care needs was developed to research methods to reduce the cost of providing services to this particular population. The results of this work group became a component of the Nebraska's Medicaid Reform Plan, which was published on December 1, 2005. Work groups were formed to examine the most appropriate methods of implementing each component of the reform plan. //2008//

/2009/ The intiatives of Medicaid reform are being revisited with plans to implement various components. The priorities of the current administration are the standardization of services statewide, transparency and accountability of our programs, and longterm the sustainability of Medicaid. The Medicaid Reform Plan proposed twenty-six initiatives intended to focus the program on its core mission to provide medical assistance for truly needy Nebraskans in a manner that promotes access to appropriate services, fosters the development and utilization of less intensive care, encourages consumer responsibility and Medicaid alternatives, and expends limited resources prudently. Several of the initiatives target management of prescribed drugs, as the fastest growing expenditure category, and long-term care services, as the largest expenditure category. Other initiatives emphasize the involvement of the consumer in appropriate health care utilization, the development of alternatives to Medicaid-financed care, and the alignment of program growth with available resources. Service limitations resulting from Medicaid Reform are generally being applied to Medicaid-eligible adults and should not directly impact the CSHCN population.

Initiatives of particular interest to the Children with Special Health Care Needs population include the identification of cost-effective telehealth technologies, the expansion of home and community-based services, and the development of a premium buy-in program for children with disabilities. A sliding fee schedule for premiums, based on family income, is expected to be piloted under the Medicaid Home and Community-Based Waiver for families with children with Autism Spectrum Disorder. Projected implementation is

January 1, 2009. //2009//

3. Process used to determine the importance, magnitude, value, and priority of competing factors upon the environment of health services in the State.

Section II, Needs Assessment, provides a comprehensive description of the processes used to determine Nebraska's MCH/CSHCN priorities. In addition, the Office of Family Health continues to draw upon the recommendations of a consultant that assisted the Department in 2001 in determining strategies for investment of Title V/MCH Block Grant Funds. This consultation was an important step in developing the framework for external allocation of Block Grant funds for the period beginning FFY 2003. This framework considered a variety of factors, including the availability of tobacco settlement funds to support local health departments and a concurrent need to support Tribal MCH efforts as part of a government-to-government relationship. This framework is being modified somewhat, but in essence will remain intact for external allocation of funds for FFY 2006 -- 2008.

In addition to these formal processes, the Office of Family Health has negotiated the demands of competing environmental factors by maintaining a focus on building its capacity to carry out the 10 essential public health services, both at the state level and at the community level. With flat or diminishing financial resources, it is clear that the Office and Title V cannot be all things for all people, nor can it pay for an extensive array of services. Rather, it is in our best interest to build public health capacity, and be aggressive in developing and maintaining a wide range of public health partnerships.

In this vein, the Office of Family Health completed an abbreviated version of the CAST-5 assessment in FFY 2005 (see Section II). During June 2005, the Office also participated in the application of the State Public Health Performance Standards. This latter activity will yield a state public health strategic plan, which in conjunction with our CAST-5 assessment, will provide the blue print for building capacity over the next few years. As a parallel activity, the framework for external allocation of Title V funds continues to include awards to local health districts for the development/enhancement of capacity to carry out the essential services as they relate to the MCH population.

/2007/ Additional activities were carried out during FY 2006 related to infrastructure building. The Title V/MCH Director is participating in the development of an updated public health strategic plan, and is part of a group identifying optimal roles and working relationships between state public health and the local health districts. //2007//

/2009/ Lifespan Health Services completed an environmental scan of planning and capacity building related to the ten MCH/CSHCN priorities. Noting that planning and infrastructure development was being carried out by public health and human service partners for a number of these priorities, focused strategy development was carried out for three priorities (Preterm birth/LBW, Overweight women/children, and Transition Services for CSHCN). See Section IV. Priorities, Performance and Program Activities for more detail.//2009//

4. Characteristics presenting a challenge to delivery of Title V services

Details are provided earlier in this section regarding a wide range of issues, including large geographic area, urban and rural differences, increasing diversity, racial and ethnic health disparities, an aging population, and special populations. These issues are ongoing challenges to the delivery of health and human services to Nebraska's MCH and CSHCN populations.

In recent years, Medicaid eligibility changes have been made in response to state budget shortfalls. As a consequence, thousands of low income children and parents no longer have Medicaid coverage. These reductions in coverage have and will continue to stress Block Grant

funded services, particularly the Medically Handicapped Children's Program, which has long been a gap filler for those children not eligible under Medicaid. In addition, both federal and Nebraska lawmakers have expressed intent to further examine ways to reduce and/or control Medicaid expenditures. Nebraska's Medicaid reform act requires that a plan be developed by December 1, 2005. /2007/ As previously stated, this plan did not make major changes to eligibility or benefits, except for the recommendations for a separate SCHIP program and for contributions from parents for children served through certain waiver programs. Operational plans for these recommendations are still pending. //2007//

Health professional shortages have been a longstanding challenge for delivering MCH services across the state. Thirty-four of 93 counties are considered all or partially included in a Health Professional Shortage Area. The number of Federally Qualified Health Centers (FQHCs) has grown to 9, but these centers do not begin to address the vast distances some families have to travel to receive care.

Historically, Nebraska has been challenged in meeting match requirements for the Title V/MCH Block Grant at the state level, resulting in a significant dependence on local match sources. This situation will likely become more acute over time, as state general funds become scarcer and tobacco settlement funds are further diverted to other uses. At the same time, local match has usually included considerable amounts of Medicaid reimbursement as match. With fewer children now eligible for the program, that income will be reduced and thus negatively impacting local match (as well as the obvious disadvantage to children at risk). These compounding factors, though not a crisis this year, may become so in the future.

A more recent issue receiving attention in Nebraska and elsewhere is the aging of the public health work force. Success in carrying out the 10 essential public health services is dependent on an adequately trained work force. As many state and community level public health professionals retire in the next few years, the recruitment and retention of new public health workers is a concern. The relatively new MPH program, offered jointly by the University of Nebraska Omaha and the University of Nebraska Medical Center, addresses this need, in part. Non-competitive compensation and limited job advancement opportunities will continue to be a deterrent to recruiting new public health professionals, especially within state government.

In summary, Nebraska's greatest challenges in providing MCH/CSHCN services are: widely and unevenly dispersed populations; increasingly diverse populations; significant health disparities among racial/ethnic minorities; shortages of health professionals primarily in rural areas; diminished financial resources; and an aging public health workforce.

B. Agency Capacity

With Title V/MCH Block Grant funding remaining flat and inflation increasing costs of doing business, maintenance of agency capacity to promote the health of all mothers and children, including CSHCN, has become increasingly challenging. As indicated in the previous section, investments in infrastructure and collaborative partnerships continue to be emphasized as the most efficient means for investing the Block Grant as a means of sustaining capacity.

Community level agencies have traditionally provided a number of services that encompass all levels of the public health pyramid. For the MCH population, services have included: home visitation; prenatal care; support services to at-risk pregnant women (particularly teens) and families with infants and children; "safety net" primary and preventive care services to children; and needs assessment and outreach activities for minority and newly arrived ethnic populations. For FFY 2006, $1.2 million in Block Grant funds are being made available for community level projects. Competitive applications were received July 1, 2005, with awards to be made by or about August 15, 2005. It is anticipated that these awards will be primarily for direct, enabling

and population based services for pregnant women, infants, children, and CSHCN.

/2007/ During FY 2006, 8 agencies were competitively awarded subgrants of Title V/MCH Block Grant funds to provide a wide range of community based services. Most of the funded projects are enabling and population based services, with some direct services provided to special populations. Two of these projects provide enabling services to CSHCN. Together, these 8 projects represent a smaller group of community based services funded through the Block Grant compared to prior years. This reflects both a shift to infrastructure building being accomplished through contracts with local health districts, and a growing proportion of the funds needed to support state level infrastructure. //2007//

/2009/ In May 2008, a Request for Applications (RFA) was issued for community-level MCH projects, with applications to be submitted by July 1, 2008. Those applications are currently being reviewed, with awards to be made for an approximate total of $1,000,000. This amount for community-level projects is less than the previous 3-year funding cycle, demonstrating the increasing demand upon the Title V/MCH Block Grant for the support of state level MCH and CSHCN infrastructure and services.//2009//

A separate Tribal set aside of $200,000 has been established for the four federally recognized Tribes headquartered in Nebraska. These funds may be used for either services or for infrastructure building. Then, to assure continued investment in community-level MCH infrastructure, $300,972 has been set aside for contracts with Nebraska's local health districts as recognized under NE LB 692.

/2009/ For the upcoming 3-year funding cycle, beginning October 1, 2008, the Tribal set aside is reduced to $150,000 per year. The set aside for local health district contracts for MCH infrastructure building has been discontinued. These two actions, along with the reduced amount of funds available for competitively selected community level projects, further demonstrates the diminishing purchasing power of the Block Grant.//2009//

State level programs receiving Title V/MCH funds that assure preventive and primary care services to pregnant women, mothers, infants, and children include the state's Perinatal, Child, and Adolescent Health Unit including school health, the MCH Epidemiology Unit (which includes the Child Death Review and PRAMS); Newborn Screening and Genetics; Office of Minority Health; Office of Women's Health; Dental Health; and Reproductive Health. In addition, the Block Grant provides partial support to the Birth Defects Registry.

Additional sources of revenue are continually being pursued to supplement state level MCH activities. Recent awards include a perinatal depression grant and a new newborn hearing screening grant. An allocation of TANF funds for home visitation ($200,000 year for 2 years) has also recently become available, providing a new source of funds for MCH services.

/2008/ The Perinatal Depression grant, referenced above, has expired, though work products developed with these grant funds will be supported and promoted in collaboration with partners. The TANF allocation for home visitation has also expired at the end of State FY 2007 (June 30, 2007), but a new apppropriation of $600,000 of state general funds per year for two years was included in the Department's funding for the 2008 - 2009 biennium. The Office of Family Health will be collaborating with the Office of Protection and Safety in administering this expanded resource for home visitation. These efforts will include coordinating efforts with Medicaid, Head Start, and the Child Abuse Prevention Fund Board in making optimal investments in evidence-based home visitation.//2008//

For CSHCN, one state-level program provides the majority of Title V-funded services to CSHCN -- the Medically Handicapped Children's Program (MHCP). Located in Medicaid Long Term Care, Safety and Independence Supports Unit, MHCP provides or pays for specialty and sub-specialty services through agency and contracted staff from a number of hospitals and private practitioners

throughout the state. Many of these professionals participate in community-based multi-disciplinary team diagnostic and treatment planning clinic sessions, and they also offer medical care and follow-up medical services. Community-based medical home family physicians and pediatricians also provide follow-up services and care coordination throughout Nebraska.

In addition, MHCP operates the Disabled Children's Program (DCP) for those children eligible for SSI. The Disabled Children's Program (DCP), which is a component of MHCP, provides funding to help families care for their children with disabilities at home. A family focused assessment process determines the need for services. Some of the funded services include: respite care; mileage, meals and lodging for long-distance medical trips; special equipment and home/architectural modifications; and care of siblings while care is received by the child with a disability/special need. The Disabled Children's Program (DCP) was designed to serve children who have a special health care need, receive monthly Supplemental Service Income (SSI) checks, are 15 years of age or younger, and live at home with their families.

/2009/As the Center for Medicare and Medicaid Services grant, EPSDT Portals to Adulthood, comes to an end, we will implement a transition clinic (consultation) as designed by this grant. The transition clinics will be targeted to CYSHCN seventeen to twenty-one to assist them in knowledge of how to move into adulthood and mange their special health care needs and adult services. The clinics/consultation will examine medical, educational, employment, housing, and all life planning aspects of becoming an adult with special health care needs.//2009//

In Nebraska, statutes pertaining to maternal and child health are found in Chapter 71, sections 2201-2208. The duties concerning the responsibility of the Nebraska Health and Human Services as to the federal early intervention program are found in 43-2509. Statutes requiring the birth defects registry are found in 71-645 through 648. Metabolic screening and associated responsibilities are found in 71-519 through 71- 524. Finally, CSFP is found at 71-2226 and WIC at 71-2227.

In 2003, LB 407 was signed into law which allocated $1,620,000 in tobacco settlement funds to the Lifespan Respite Services program for the biennium from July 1, 2003 through June 30, 2005. Use of this source of funds for respite care has allowed expansion of this service and has resulted in more MHCP funds being devoted to medical and rehabilitative services.

/2007/ Nebraska continues to strive to promote and support culturally competent approaches to service delivery. Data collection and analysis, whenever possible, addresses race and ethnicity, and to a lesser degree, language. For instance, Nebraska stratifies its PRAMS data by race and ethnicity, and has obtained CDC approval to include Nebraska Native American women who deliver outside of Nebraska in its sample, to assure that these women are adequately represented in data collection. Nebraska MCH/CSHCN programs benefit from the efforts of other offices in HHSS to collect culturally relevant data, such as the Minority Behavioral Risk Factor Survey. During the comprehensive needs assessment completed in 2005, analysis by cultural groups was extensively done and disparities among groups was one of the criteria used in prioritizing needs.

HHSS has a long history of offering and promoting training in cultural competency for both its staff and stakeholders. It established an Office of Equity and Diversity which sponsors training and events for HHSS employees. Culture and language are frequently incorporated into the wide range of training and technical assistance activities sponsored by the Office of Family Health for its community partners. The Office of Family Health has a strong working relationship with the Office of Minority Health and has collaborated on training events tailored for specific audiences. In addition, that office sponsors each year the Minority Health Conference which is an outstanding event featuring national speakers and draws attendees from across the state.

Collaborations with community leaders and groups are integral to participatory government. The

Nebraska Minority Public Health Association is a key stakeholder and partner, with its members participating in and contributing to needs assessments and major initiatives over the years, including the 2005 needs assessment. The Office of Family Health has ongoing working relationships with Northern Plains Healthy Start and Aberdeen Area Tribal Health Directors' programs, and works closely with the Native American Liaison in the Office of Minority Health. Individual programs work with specific communities and community leaders in developing culturally relevant initiatives, such as the Abstinence Education Program's Latino events in 2005 and Native American focused activities in the Panhandle in 2006.

Since FY 2003, the Office of Family Health maintains a set-aside of Title V funds for those federally recognized Tribes headquartered in Nebraska. This set-aside recognizes the special government-to-government relationship between HHSS and the Tribes, as well as a priority to meet the health needs of the Native American MCH populations. In allocating funds for other community based programs, the needs of culturally diverse groups are directly addressed in the RFPs, through expectations for addressing the needs of racial and ethnic minorities and engaging representatives from culturally diverse groups in program planning and development. Further, the criteria for funding decisions includes a consideration of relative need among geographic areas, including needs specific to racial and ethnic groups.

Further, the CLAS standards are an expectation outlined in the Title V RFP for communities and these standards are thus incorporated by reference into the awards made to community subgrantees. //2007//

C. Organizational Structure

The Nebraska Department of Health and Human Services Regulation and Licensure (HHS R&L) is now the State Title V/MCH agency. The Department is one of three agencies that form the Health and Human Services System. The other two agencies are the Department of Health and Human Services and the Department of Health and Human Services Finance and Support. LB 301, passed and signed into law in 2005, officially transferred Health Services, including the Office of Family Health and the administration of the Title V/MCH Block Grant, to HHS R&L.

Home and Community Based Services for Aged and Physically Disabled, including the Medically Handicapped Children's Program, have been administratively transferred to the Department of Health and Human Services Finance and Support (HHS F&S). Thus HHS F&S is now Nebraska's Title V/CSHCN Agency.

/2007/ During the 2006 legislative session, LB 994 was passed and signed into law, statutorily transferring Home and Community Based Services for Aged and Physically Disabled, including the Medically Handicapped Children's Program, to the Department of Health and Human Services Finance and Support (HHS F&S). //2007//

/2008/ As indicated in the Overview, LB 296 was passed and signed into law in 2007, and went into effect July 1, 2007. This bill reorganizes the Health and Human Services System, forming one agency: the Department of Health and Human Services. This new agency has 6 divisions, with Title V/MCH in the Division of Public Health and Title V/CSHCN in the Division of Medicaid and Long-Term Care.//2008//

The Office of Family Health, HHS R&L, provides the principle oversight for administration of the Title V/MCH Block Grant. The MCH Planning and Support Unit reports to the Administrator for the Office of Family Health who is also the Title V/MCH Director. The unit includes the Federal Aid Administrator and an Administrative Assistant, for a total of 2.0 FTE. The MCH Planning and Support Unit is responsible for organizing and leading the development of the annual plan and report, administers sub-grants to communities, monitors allocations to other HHSS units and programs, and coordinates Title V funded activities with other public health programs within the Office and agency./2008/ The Office of Family Health has been combined with the Office of

Women's Health, forming Lifespan Health Services.//2008//

Other programs and units within the Office of Family Health include: Commodity Supplemental Food Program; WIC; Immunizations; Newborn Screening and Genetics (including Newborn Hearing Screening); Perinatal, Child and Adolescent Health (including school health, Early Childhood Comprehensive Systems, and Abstinence Education); Reproductive Health; and the MCH Epidemiology Unit (includes includes PRAMS, Child Death Review, and SSDI-supported activities.)/2008/Effective July 1, 2007, all references to the Office of Family Health are to the functions and activities that are now a part of Lifespan Health Services.//2008//

Special Services for Children and Adults has been changed to Home and Community Based Services for Aged and Physically Disabled in HHS Finance and Support. The Title V/CSHCN Director, who is also the co-director for Part C of the Individuals With Disabilities Education Act, is the Administrator for this office. Home and Community Based Services for Aged and Physically Disabled houses the following programs: Medically Handicapped Children's Program (MHCP), Home and Community-Based Medicaid Waiver for Aging and Disabilities, Katie Beckett Plan Amendment Services Coordination, Social Services Block Grant for the Aged and Disabled (Title XX), Disabled Persons and Family Support, Adult Protective Services, SSI Disabled Children's Program, Nebraska Resource Referrals System, Genetically Handicapped Persons Program, Early Intervention Waiver, and Early Intervention and Medicaid in Public Schools Programs.

/2009/Vivianne Chaumont, the Director of Medicaid and Long Term Care, is the co-director for Part C of the Individuals With Disabilities Education Act. The Medicaid Long Term Division houses the following programs: Medically Handicapped Children's Program (MHCP), Home and Community-Based Medicaid Waiver for Aging and Disabilities, Katie Beckett Plan Amendment Services Coordination, Social Services Block Grant for the Aged and Disabled (Title XX), Disabled Persons and Family Support, SSI Disabled Children's Program, Nebraska Resource Referrals System, Genetically Handicapped Persons Program, Early Intervention Waiver, and Early Intervention and Medicaid in Public Schools Programs. //2009//

Early Intervention is co-administered with the Nebraska Department of Education.

Title V -- both MCH Planning and Support and MHCP -- maintain very collaborative relationship with the Medicaid program and Vital Statistics Management Unit, which are both located in the Finance and Support department, as well as the Data Management Unit in the Regulation and Licensure department. In addition, Title V works with a number of programs throughout NHHSS including: child care, juvenile services, mental health and substance abuse, developmental disabilities, minority health, health promotion and disease prevention, women's health, communicable diseases, dental health and rural health. Of these areas outside of Family Health and Aging and Disability Services, only minority health, data management, dental health, communicable diseases and women's health receive federal Title V funds. An organizational chart displaying the agencies and units is found as an attachment.

/2008/Medicaid is now within the Division of Medicaid and Long-Term Care and Vital Statistics is now within the Division of Public Health. Both Divisions are part of a single agency, NE Department of Health and Human Services.//2008//

Health and Human Services System programs funded by the Federal-State Block Grant Partnership budget are described in the previous section. Community-based and Tribal programs supported by the Block Grant for the period of FFYs 2006 -- 2008 will be determined on or about August 15, 2005.

/2009/Community-based and Tribal programs supported by the Block Grant for the period of FFYs 2009 - 2011 will be determined on or about August 15, 2008.//2009//

/2008/ In August 2006, Governor Heineman announced his proposal to restructure the Health and Human Services System (HHSS), which currently operates as three distinct agencies. This has resulted in the passage of LB 296.

In the coming year (effective July 1, 2007) LB 296 will go into effect. This will reorganize the existing three agencies into one single agency, headed by a Chief Executive Officer. The Medically Handicapped Children's Program (MHCP) and the Disabled Children's Program will be located in Medicaid Long Term Care, Safety and Independence Supports Unit. //2008//

/2008/ Nebraska has received a system change grant, Early Periodic Screening and Diagnostic Treatment Portals to Adulthood. This grant establishes protocols and procedures to transition children from pediatric services to adult medical services. The children targeted would be the CSHCN. Current CSHCN clinics, described in a later section, are being used to pilot the transition component. //2008//

An attachment is included in this section.

D. Other MCH Capacity

As described earlier, the MCH Planning and Support Unit within the Office of Family Health has primary responsibility for the ongoing administration of the Title V/MCH Block grant. /2008/MCH Planning and Support has been re-named Planning and Support within Lifespan Health Services.//2008//

Programmatic activities are carried out by various staff within the Office of Family Health. The Perinatal, Child and Adolescent Health Unit within Family Health is responsible for school health, adolescent health including abstinence education, child health, Healthy Mothers, Healthy Babies toll-free line, perinatal issues such as perinatal depression, and the Early Childhood Comprehensive Systems (ECCS) grant. This unit is staffed by 5.0 full time staff./2008/ The functions of the Office of Family Health are now a part of Lifespan Health Services.//2008//

The MCH Epidemiology Unit was created in FFY 2004, and includes PRAMS, Child Death Review, and SSDI activities. It is staffed by 3.5 FTE and a 0.75 contract employee.

The Newborn Screening and Genetics Program staff is responsible for the oversight of Nebraska's newborn metabolic screening activities, genetics planning and development, and newborn hearing screening. It is staffed by 5.0 full-time employees and 1.0 temporary employee.

In addition to administering the Title X grant, the Reproductive Health Program carries out a wide range of activities related to women's and adolescent health and is staffed by 3.7 full-time employees.

/2007/ The Reproductive Health Program is currently staffed by 2.4 FTE, with an additional vacant position and a part-time temporary employee. //2007//

//2008/ The Reproductive Health Program is now staffed with 3.4 permanent FTE positions.//2008//

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides supplemental food, nutrition and health education, and related services through 14 local agencies across the state. The program currently serves over 40,000 participants each month. WIC has provided leadership in MCH nutrition activities, including breastfeeding promotion and support. The State WIC Director is Nebraska's representative to the Association of State and Territorial Public Health Nutrition Directors (ASTPHN). The program is staffed by 9 full-time FTEs, with an additional 2 information technology FTE permanently assigned to the program. The Commodity

Supplemental Food Program serves an additional 14,000 individuals each month, the majority being seniors. This program is staffed by 1 full time FTE.

Also administered within the Office of Family Health, the Immunization Program manages CDC 317 and Vaccine for Children funds, and oversees public immunization clinics and the registry supporting these clinics. The program is staffed by 6.25 full time FTEs and a 1 temporary FTE.

/2007/ The Immunization Program now has 7.25 permanent FTEs. //2007// /2008/The Immunization Program is now a part of Lifespan Health Services.//2008//

The Office of Family Health Administrator participates in a wide range of collaborative activities and initiatives described elsewhere. She is supported by a 0.2 FTE staff assistant. Paula Eurek, BS, RD, Title V/MCH Director, has been an employee of Nebraska Health and Human Services for 21 years. Her maternal and child health experience includes two years of community-level experience as a WIC nutritionist and over 10 years as a state-level WIC nutritionist and administrator. Ms. Eurek assumed the roles of Administrator for the Office of Family Health and Title V/MCH Director in December, 1995. She had prior experience as the interim MCH Division administrator in 1988-1989. She is currently the Project Director for Nebraska's Integrated Comprehensive Women's Health Services in MCH Programs grant project, and provides general oversight to Nebraska's ECCS grant project and newly awarded perinatal depression grant.

/2007/ Ms. Eurek has now been with the Department for 22 years, and the Integrated Comprehensive Women's Health Services in MCH Programs grant project has expired. //2007// /2008/ Ms. Eurek is now an administrator in Lifespan Health Services and has been with the Department for 23 years.//2008// ***/2009/ No longer a registered dietitian (RD), Ms. Eurek will observe 25 years with the State of Nebraska in September 2008. //2009//***

In addition to administering MHCP, the Home and Community Based Services for Aging and Physically Disabled is responsible for a number of CSHCN services and activities. It partially funds the Answers4Families website which includes comprehensive information for families of children with special needs, school nurses, foster and adoptive families, and families, agencies and others concerned with children's mental health. The website hosts discussion listservs (discussion groups for these populations). As well as information and Internet listservs for other populations with special needs. Nebraska Resource Referral System (NRRS), which includes over 8,000 social services type resources including child care, respite coordinator information, medical/health and public health information, food pantries, is accessible through this web portal. Addresses: http://www.answers4families.org and http://www.answers4families.org/nrrs/.

/2009/ The MHCP clinic list and addresses of local workers are available on Answers4Families. Address: http://www.hhs.state.ne.us/hcs/programs/MHCP.htm.//2009//

The Home and Community based Services for Aged and Physically Disabled is a Co-Lead for Part C of the Individuals with Disabilities Education Act along with the Nebraska Department of Education, Special Populations. Consequently, the Family Partner full time position represents families for both the Early Development Network programs and the CSHCN programs. The Family Partner attends CSHCN training for CSHCN staff, national MCH/CSHCN meetings and is a member of advisory groups to the CSHCN Program. The CSHCN Nurse Consultant staff member has been a family member of a CSHCN in the past but this currently is not the situation.

/2009/Development Tips is tracking Infant Progress statewide in Nebraska started in 2000. The program provides specialized development follow-up for babies who have been in the Neonatal Intensive Care Unit. The Development TIPS program has two main goals: To provide a standard system of developmental follow-up for all infants who have had an NICU experience in Nebraska and to gather information about how babies who have been in the NICU grow and develop, so we can learn how to better meet their unique needs in the future. EDN Services Coordinators are partners with 10 departments/programs to

direct referrals to the appropriate service.

In 2007, two additional partners where added to the list of partners (Bryan LGH and Alegant Lakeside in Omaha). Developmental TIPS also plans to begin data collection for the next three years on children that were part of the program who are now entering first grade. //2009//

Mary Jo Iwan, BA, Title V/CSHCN Director, has been an employee of Nebraska Health and Human Services for 33 years. She has extensive experience working in programs to serve persons with disabilities, as well as broader based programs such as the Social Services Block Grant. Ms. Iwan assumed the role of Title V/CSHCN Director in 1991. She is actively involved in a number of Governor-appointed organizations, including the Developmental Disabilities Council and the Governor's Task Force on Alzheimer's Disease and Related Disorders. She is also involved in activities at the national level, including membership on the Health Care Financing Administration (HCFA) Non-Institutional Long-term Care Technical Assistance Group and HCFA Home and Community Quality Work Group.

/2008/ Ginger Goomis, MBA, Title V/CSHCN Director, has been an employee of the State of Nebraska for 34 years. She is currently the administrator of long-term care programs in the Medicaid and Long-Term Care Division of the Nebraska Department of Health and Human Services. Previous work assignments have included research, budgeting, and management responsibility for numerous social service programs. She serves on the Nebraska Planning Council on Developmental Disabilities and is actively involved with Nebraska's Medicaid Reform efforts, including the Long-Term Care Insurance Partnership and the Money Follows the Person Demonstration. //2008//

E. State Agency Coordination

Examples of State Agency Coordination specific to Title V/CSHCN include MHCP involvement in a Federal Centers for Medicare and Medicaid Services (CMS) System Change Grant (Portals to Adulthood) to develop protocols an processes around transition youth with disabilities to adult medical services by working with existing MHCP clinics and physicians with the University of Nebraska Medical Center. In addition this project incorporates Nebraska Easter Seals, Department of Education, and local HHS workers to expand the transition plan to include a medical component, ensuring appropriate medical care for Nebraska's low income disabled children. One exciting result of the Portals to Adulthood project is the building capacity of physicians with knowledge of the needs of adolescents with disabilities, by the participation of the faculty of the University of Nebraska Medical Center and the development of a specialized curriculum for resident physicians. Through this grant we have established a two tiered system of clinics, where the first tier is used as the assessment piece to identify a plan for the future and the second as the follow up.

Nebraska HHSS is part of a coordinated funding committee that encompasses Vocational Rehabilitation, MHCP, the Developmental Disabilities Council, League of Human Dignity, Aged and Disabled Medicaid Waiver, Easter Seals Society, United Cerebral Palsy, the Disabled Persons and Family Support Program, and other private non-profit programs to assure that individuals receive services for which they are eligible. This committee of providers and advocates has met to discuss individual care plans and find solutions which make the most efficient use of program resources for the past eighteen years.

/2009/The Coordinated Family Committee continued to meet on a bi-monthly basis to review and discuss funding of individual cases. Next year, the committee plans to have a series of presentations to expand the committee's knowledge of other resources that offer funding assistance. In addition, they will be part of the review and rewriting of MHCP regulations//2009//.

/2009/Child Abuse Prevention Treatment Act (CAPTA) is improving Nebraska achievement under the federal mandate. EDN has collaborated with Juvenile Court Judges, child development experts, and Protection and Safety CPS staff to provide statewide training to all professionals and families involved in child abuse and neglect court system. EDN has provided several trainings to assist all entities to understand the law and to work together to integrate the system.//2009//

/2009/ Since 2005, there have been trainings on the local level on CAPTA to CPS and EDN workers. These trainings are now on-going to work on issues and problems surrounding implementation of the mandate.//2009//

/2009/ The EDN Program Coordinator participates on the Newborn Hearing Screening (NHS) Advisory Committee under Public Health NHS manager. The committee began in 2006 and meets quarterly. The NHS is to establish an Early Hearing Detection Program and a single point of entry for service with referrals made to the EDN Services Coordinators. The EDN Services Coordinators have been trained on the NHS services.//2009//

The Disabilities Determination Unit (DDU) for Social Security and SSI is located in the Nebraska Department of Education. The DDU sends notification to MHCP on a regular basis of children determined eligible for SSI, at which time MHCP sends a notice to the family describing possible services they may receive and how to apply. This relationship ensures that families receiving SSI for their children are notified of their potential eligibility for services.

/2009/ The Disability Determination Unit of Social Security provides a continual stream of referrals to the MHCP. As the result of the notification of SSI eligibility, MHCP workers have been able to provide immediate notification to families regarding the availability of services through SSI-DCP. //2009//

With the administration of Nebraska's Title V/MCH Block Grant located within the Office of Family Health, abundant opportunities exist to coordinate Block Grant investments with a wide range of MCH programs and activities funded through other sources, including WIC, CSFP, Immunizations, and Reproductive Health. Then, with the Office of Family Health being in the same branch of HHS R&L with the Offices of Rural Health, Minority Health, Women's Health, Public Health, and Disease Prevention & Health Promotion, another and even more significant level of collaboration opportunities exist. References to these collaborative efforts are found throughout this application./2008/Administration of Nebraska's Title V/MCH BLock Grant is now within Lifespan Health Services, which also includes the former Office of Women's Health. Collaboration opportunities continue and are enhanced as a result of the reorganization, including the formation of the Division of Public Health.//2008//

Within the larger Health and Human Services System, the Office of Family Health has ongoing and active partnerships with Child Care Subsidy, Child Care Licensing, and Protection and Safety. It has expanded its collaboration with Behavioral Health, in conjunction with the Mental Health Component of the ECCS grant, the SAMSHA SIG project, and the newly awarded perinatal depression grant./2008/Lifespan Health Services, as the successor to the Office of Family Health, continues these working relationships and adds additional ones.//2008//

The Nebraska Department of Education (NDE) is an active partner with /2008/Lifespan Health Services//2008// in carrying out early childhood programs and initiatives, including ECCS. The Title V/MCH Director is reciprocally active in the NDE's Early Childhood Policy Initiative, the development of Early Learning Guidelines, and administration of the statutorily required READY Act (early learning materials for all Nebraska newborns and their families).

Nebraska Title V has a long-standing working relationship with the state's urban health

departments. Both the Douglas County Health Department and the Lincoln/Lancaster County Health Department currently receive Title V funds for specific activities, but each have been partners in a wide range of initiatives. For instance, representatives of the Douglas County Health Department actively participated in the recently completed needs assessment and are active in current projects such as Safe Sleep. A staff person with the Lincoln/Lancaster County Health Department (LLCHD) also participated in the needs assessment process and has been active in the Breastfeeding Initiative.

Nebraska Title V also works with smaller local health departments and other community health agencies, both as a funder and a collaborator. As previously stated, $300,072 has been set aside for contracts with Nebraska's LB 692 designated local health districts for the purposes of building and sustaining MCH infrastructure. In addition, as the newer local health districts have matured, their staff has become increasingly engaged in state-level activities and initiatives, such as Safe Sleep and Breastfeeding Promotion and Support.

Nebraska's federally qualified health centers continue to be key partners in serving the MCH population. The Charles Drew Health Center, through its Healthy Start program, provides enabling services to the perinatal population of northeast Omaha. The Office of Family Health works whenever possible to connect state level activities with Omaha Healthy Start. In addition, Hope Medical in Omaha, a Nebraska Title V funded project, subcontracts with Charles Drew Health Center for selected services. Similarly, Panhandle Community Services, the location of the FQHC in western Nebraska, has been a subcontractor for the Panhandle Partnership's Title V project.

Local health departments, federally qualified health centers, and applicable Title V supported community projects are key partners in assuring that pregnant women access prenatal care and help identify pregnant women and children eligible for Medicaid services. In turn, Medicaid presumptive eligibility for pregnant women continues to be determined by many of these providers.

Nebraska Title V continues its working relationship with the Primary Care Office by sharing data and information. The Primary Care Office assisted with geocoding as part of the comprehensive needs assessment.

Nebraska Title V works closely with a number of programs and departments within the University of Nebraska Medical Center (UNMC). The Munroe-Meyer Institute is a close collaborator on a number of CSHCN projects. A new relationship was established with the University of Nebraska ---Omaha, for the CSHCN component of the comprehensive needs assessment. Many other working relationships exist with various faculty and staff throughout Nebraska's university systems, including development and support of internet-based services for families of CSHCN and for school nurses.

Nebraska has a relatively young Masters in Public Health program, a combination degree program sponsored by the University of Nebraska Medical Center and the University of Nebraska at Omaha. The MPH program finished its first semester in operation in May, 2002, and since has acquired accreditation. This program, along with the newly established Great Plains Public Health Leadership Institute, provide opportunities for collaborations around staff development and building public health capacity./2008/ The College of Public Health was formed in 2007.//2008//

Collaborations were expanded during FFY 2004 through Together for Kids and Families, Nebraska's State Early Childhood Comprehensive Systems project, including HHSS and Department of Education staff working with program and services for homeless students and families. In addition, Office of Family Health are actively working with Medicaid Managed Care staff on a prenatal care quality improvement project.

An ongoing project that has depended on a close partnership with the Nebraska Department of

Education is implementation of the READY Act. This act, passed by the Legislature in 2002, requires that materials be provided to the parents of all infants born in Nebraska that promote early learning opportunities and healthy, safe child development. The Title V/MCH Director was the lead HHSS contact for this project, and helped coordinate the health and safety content of the materials and planned for the distribution. The Department of Education took the lead in the overall design and production. A Title V/MCH funded project field tested the materials with young parents. The booklet, "First Connections with Families" was completed late in 2003, and distribution started in January 2004. The Perinatal, Child and Adolescent Health Unit is responsible for ongoing distribution. Participating hospitals distribute to new parents, while other parents receive via the mail 3-4 months after birth.

/2009/ Lifespan Health Services staff continues to collaborate with the Nebraska Department of Education in the distribution of the First Connections with Families booklets to Nebraska families of newborns. During FFY 07, 20,978 booklets were mailed directly to families with newborns. Other families received their copy at the birthing hospital. Twenty-five Nebraska hospitals distributed the booklets to newborn families. The booklet was translated into Spanish with other federal funds. A tear-out postcard was placed in the second edition of the English version of "First Connections" that families can use to request a Spanish copy. Twenty-eight Spanish booklets were mailed to families of newborns, as requested.//2009//

/2007/ Over the past year, collaborations with Medicaid and EPSDT have been expanded and enhanced through various projects and initiatives. /2008/Lifespan Health Services//2008// is working closely with Medicaid/EPSDT personnel in operationalizing child care health consultation through Medicaid-contracted public health nurses. This arrangement is a direct outgrowth of Nebraska's ECCS project, Together for Kids and Families. MCH Planning and Support is also working with Medicaid/EPSDT staff in the start up of a new community based Title V project in northeast Nebraska, in the provision and financing of enabling services including home visitation. Medicaid/EPSDT staff are also participating in the National Center for Children's Health Care Quality's Newborn Hearing Screening-Medical Home Learning Collaborative. These are just a few examples of the routine, working relationship between Title V/MCH and EPSDT.

Nebraska continues to offer presumptive Medicaid eligibility to pregnant women, with Title V/MCH community based providers either offering eligibility determination or making referrals. During this past year, Healthy Mothers, Healthy Babies helpline was assessed and plans are underway to make it a more useful tool for connecting pregnant women and infants to health care and Medicaid. In addition, /2008/Lifespan Health Services//2008// is administering a pilot project for supportive services for pregnant women, funded through allocated TANF funds. This project, just getting underway, includes a network of providers in the Omaha community that together will provide supportive services and make referrals to care and other resources, such as Medicaid. //2007//

/2008/ The TANF funded project, described above, will be completing its pilot phase at the end of calendar year 2007. TANF funds have again been budgeted for this project for the SFYs 2008 and 2009. Contractor(s) will be selected through a competitive process, to continue/replicate successes identified during the pilot phase.//2008//

/2009/ The TANF funded project selected in FFY 2008 is located in Lexington, Nebraska, and the contactor is Lutheran Family Services. The focus is on improving birth outcomes for at-risk women, particularly racial/ethnic minorities and new immigrants.//2009//

/2009/ Of note during FFY 2008, the Divisions of Children & Family Services and Medicaid & Long Term Care jointly issued a Request for Bids for home visitation services. This joint RFB was in response to two, distinct appropriations made by the Nebraska State Legislature in 2007. One appropriation was for home visitation as secondar prevention for child abuse and neglect. The other appropriation was for nurse home visitation to

improve outcomes for Medicaid eligible pregnant and parenting teens. Lifespan Health Services collaborated in the developement of the RFB, particularly in establishing expectations for evidence-based models.

DHHS Division of Medicaid and Long Term Care also developed an interactive curriculum to promote provider screening for social-emotional and behavioral development in children ages birth to five years. Continuing education credits are available to physicians and nurses who complete the curriculum. Plans are underway to develop similar curriculums for development in children 6-9 years and 10-17 years. These curriculums add to and are located with the curriculum developed by Lifespan Health Services for perinatal depression screening.//2009//

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	18.1	18.4	21.8	18.8	
Numerator	219	225	219	194	
Denominator	120746	122049	100490	103084	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2007
2007 HDD data is released in October of 2008.

Notes - 2006
2006HDD data is released in October of 2007.

Notes - 2005
Data is significantly under reported (based on 82% of Nebraska hospitals reporting).

Narrative:
/2008/Nebraska Health and Human Services contracts with the Nebraska Hospital Association for annual Hospital Discharge Data which is generally available in October of every year (2006 in October 2007). In the past the software and technical support has been provided by a private insurance company. In 2004 the company discontinued support of the software and as a result the reporting dropped form 95% of Nebraska hospitals to 82%. Therefore it is unclear what Nebraska rates truly are. There is however a increase over the past 5 years.
The highest incidence of hospitalization is to children 1-4 years of age.

Nebraska no longer has an asthma program at the state level and efforts to conduct surveillance have been slow. //2008//

/2009/

Nebraska's Hospital Discharge Data (available in October of each year) reporting continues to improve, however issues have not been completely resolved. Nebraska does not have an Asthma Program. The last epidemiological report was completed in 1998. This report found that the highest emergency room and hospitalization rates for asthma occurred among children under the age of 14. As an example the e-room rate for 0-4 year olds was 32.6 and 5-14 years was 35.4 per 10,000 while the total state rate was 24.6. //2009//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	97.2	81.7	98.7	98.8	98.3
Numerator	11811	10315	12575	12933	13277
Denominator	12153	12618	12743	13094	13510
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
/2008/Medicad enrollment has increased slightly and is maintaining high compliance with the initial periodic screen for infants. Nebraska does well on EPSDT until the child reaches 3 years of age and older and we see a considerable drop in periodic screening. //2008//

/2009/ There is no change in this indicator.//2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	48.7	91.9	86.6	87.7	84.7
Numerator	904	1096	862	876	866
Denominator	1856	1192	995	999	1023
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Medicaid was asked to verify and interrupt the drop. Staff stated 2003-2005 should have been reported 82.9, 86.6, 86.6%.

Narrative:

/2008/Nebraska had a considerable drop on ESPDT rates for CHIP over the last fiscal year. Enrollment in CHIP is up and the number of infants screened is higher despite the rate reduction. The data for this indicator is a sub-set of indicator #02HSCI so, while the overall Medicaid Kids Connection initial periodic screens have hit nearly 100% over the past couple of years CHIP enrollees have not. //2008//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	73.6	71.1	63.0	66.4	70.5
Numerator	19074	18670	16429	17712	18231
Denominator	25900	26273	26085	26659	25848
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births). Over 2% of the data for this PM is missing/unknown.

Notes - 2006
Over 6% of the data for this PM is missing/unknown.

Notes - 2005
Provisional data due to birth certificate conversion in 2005.

This Indicator is impacted by the timing an dnumber of prenatal care visits.

NCHS confirms that conversion has consistently shown a drop in access to 1st trimester care. The change is due to source of data. The new source is however, thought to be more accurate.

Therefore, 2005 will not be comparable to 1999-2004.

Narrative:
/2008/ In 2005 Nebraska Vital Statistics converted to the 2003 standard NCHS birth certificate. One significant change was the data field first prenatal care visit which previously was reported by month and is now reported by actual date (more accurate). These data sources are not the same and are not comparable (verified by NCHS staff).

Data for 2005 and 2006 remains provisional. There is a slight improvement in the provisional data over the two years. Because of the provisional nature of the data it is unclear if any change has occurred. Staff has been making informal efforts to inform partners of the changes in he data //2008//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	96.7	96.5	96.8	96.9	96.9
Numerator	160596	152470	153502	154580	155320
Denominator	166000	158000	158500	159580	160320
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
/2008/ This indicator remains stable hovering in the 97% range. //2008//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	64.5	57.8	61.3	61.7	63.6
Numerator	18308	17525	18869	19384	20265
Denominator	28398	30301	30763	31427	31870
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
/2008/ Recruitment and retention of dental providers remains a significant issue for Nebraska's children. //2008//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	36.2	32.8	32.6	36.5	37.0
Numerator	1060	938	967	1101	1375
Denominator	2927	2858	2964	3016	3715
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is					

fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Num = NE CONNECT number of children 15 and younger receiving services (MHCP and/or SSI-DCP)FY 2007.

DEN = Table 7 SS1 payments Dec, 2007 via Healthy and Ready to Work

Notes - 2005
Num = NE CONNECT number of children 15 and younger receiving services (MHCP) FY 2005.

DEN = Table 7 SSA Dec, 2005 via Healthy and Ready to Work (http://www.hrtw.org/youth/data.html.ssi05)

Staff is unclear how to report.

Narrative:
/2008/The Nebraska CSHCN (MHCP) program does not provide rehabilitative services. So this indicator measures those who received any services in the 2006 funding year. The number served has decreased while the number of children receiving SSI has increased causing a reduction in the indicator //2008//

/2009/The number SSI Beneficiaries have increased while the number receiving benefits through Nebraska's Medically Handicapped Children's Program have decreased. //2009//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2006	matching data files	84.7	5.8	7

Narrative:
/2008/Nebraska converted to the electronic 2003 NCHS birth certificate format in 2005. Staff have been formed a work group to address low birth weight and prematurity. An extensive problem analysis has been conducted in which both poverty and racism have been identified as contributing factors.//2008//
/2009/A report from the workgroup is attached to the Needs Assessment Summary (Section IIC).//2009//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

indicators for Medicaid, non-Medicaid, and all MCH populations in the State					
Infant deaths per 1,000 live births	2006	matching data files	4.8	3.4	4.3

Narrative:
/2008/While other indicators demonstrate a negative gap between the Medicaid and non-Medicaid population the infant mortality rate continues to lower for the Medicaid population. //2008//

/2009/The infant mortality rate is now higher for the Medicaid population for the first time since 2003.//2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	66	84.5	71.5

Narrative:
/2008/Nearly 43% of deliveries were paid for by Medicaid in 2006. Medicaid's policy of presumptive eligibly should eliminate problems with access early prenatal care. Thus these differences are more likely attributable to characteristics of the population and not the Medicaid program. //2008//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to	2006	matching data files	55.6	70.6	66.4

expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					

Narrative:
/2008/ This data has changed very little over the past few years. Getting early prenatal care and then consistent prenatal care is a challenge for those receiving Medicaid services.//2008//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2007	185

Narrative:
/2008/These levels have not changed in a number of years.//2008//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2007	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2007	 185 185

Narrative:
/2008/These levels have not changed.//2008//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

pregnant women.		
Pregnant Women	2007	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2007	185

Notes - 2009
Pregnant women 18 or younger

Narrative:
/2008/These levels have not changed.//2008//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:

/2008/Nebraska continues to improve and refine the data linkage capacity. While The "MCH Program" has the ability to obtain data in a timely manner it is at various levels of proficiency and experience.

Nebraska has been fortunate to receive funding from CDC for the Early Hearing Detection and Intervention Tracking, Surveillance, and Integration project which will further SSDI efforts by linking the birth, newborn hearing, and Connect (CSCHN)databases.

The linkage of the birth file with the WIC eligibility file has been the least successful on an annual basis and capacity improvements will be a focus of data linking projects of SSDI. As described in detail in HSCI #01 the Hospital Discharge Database is currently experiencing reporting issues that should be cleared up for the 2006 dataset.

Nebraska PRAMS has recently been awarded a five-year cooperative agreement carrying its activities into 2011. //2008//

/2009/ Nebraska is set to fully implement the Nebraska State Immunization Information System by December 2008. The NESIIS is linked with Vital Records system. Other changes in the up-coming year are the implementation a new computer system for Medicaid and then WIC. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	2	Yes
Youth Tobacco Survey	3	Yes
Nebraska Risk and Protective Factor Student Survey	3	Yes

Notes - 2009

Narrative:
/2008/The Nebraska YRBS is conducted biannually and is currently being administrated (2007). However, because the largest school district (Omaha Public Schools) does not participate the results are not generalizable to the entire state.

The Pediatric Nutrition Surveillance System is WIC data aggregated by CDC. Nebraska uses this data on a limited basis as it is restricted to a sub-set of the population.

Perhaps the best source of information about the tobacco use by youth is the Nebraska Risk and Protective Factor Student Survey (NRPFSS) which was administered in the fall of 2003 and 2005 to Nebraska students in grades 6, 8, 10, and 12. The survey is designed to assess adolescent substance use, anti-social behavior, and the risk and protective factors that predict adolescent problem behaviors. The Nebraska survey is adapted from a national, scientifically validated survey and contains information on the risk and protective factors that are: 1) locally actionable, 2) not obtainable through any other source, and 3) more highly correlated with substance abuse. One of the goals of the survey was to provide schools and communities with local level data to assist in planning comprehensive, evidence-based prevention initiatives.//2008//

/2009/DHHS has collaborated with the Nebraska Department of Education to convene the school-based student health survey initiative. This initiative brought together educators,

researchers, public health, and data users to discuss the three surveys. The discussion was about methodology, response rates/participation, and decreased school time. A set of recommendations has been made and are being vetted to funders and administrators. The goal is to implement all three surveys successfully while minimizing school interruption. //2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The investment of Title V funds in Nebraska is driven by a number of key factors. The first set of factors is the MCH/CSHCN priorities identified through the needs assessment completed in 2005. These priorities will guide funding decisions for FFY 2006 and beyond. A second important factor was the technical assistance consultation provided by Donna Petersen in 2001. This consultation provided recommendations for how to balance investments in infrastructure and local services. Next, Nebraska's emerging local health districts, supported through tobacco settlement funds, have offered a unique opportunity for building MCH capacity. Finally, though the State's financial status is not as gloomy as in recent years, fiscal constraint is still needed.

Between 2000 and 2003, Medically Handicapped Children's Program applications have more than tripled. Going from 132 in 2000 to 580 in 2003, yet the available funding has stayed the same. We continue to balance between the rising need and the stagnant funding to meet the increasingly complex medical needs of CSHCN.

Thus, decisions on the allocation of Title V funds continues to be a balance between meeting the needs of the MCH/CSHCN populations, capitalizing on opportunities to build infrastructure, and sustaining basic, ongoing services in a time of limited financial resources. Even more than in previous years, collaboration with other programs and integration of financial resources is critical to address priorities. In this regard, it must be pointed out that the term Title V Program does not capture the essence of the work carried out through Title V in Nebraska. For both the MCH and the CSHCN populations, the integration of resources, both financial, human and logistical, is key to addressing priority needs. Title V funds are being increasingly invested in basic infrastructure, with the support of other health and human services programs augmenting interventions.

/2008/ In 2006, the number of MHCP applications increased by 9% and the number of applicants without insurance coverage increased by 12%. These figures demonstrate the growing need for medical insurance coverage. MHCP is filling a gap in services, providing necessary medical care to families with children with complex medical needs.

/2009/ Connect reports indicate a slight decline in the number of MHCP clients covered under Medicaid and private insurance this year. This is due to a modification of the insurance fields on the Connect database in order more accurately track the number of CYSHCN and their insurance coverage. The modification will provide additional information regarding insurance coverage. The system will record the specific name and address of the insurance company providing coverage, along with the insurance coverage period. This will provide current, accurate, and detailed insurance coverage for each MHCP client. It will allow us to track fluctuations in private insurance coverage and increase the ability to track and report data in this area.//2009//

Each year the need for MHCP services has grown, and continued collaboration with other programs and the inclusion of existing financial resources, when available, has become essential to meeting the medical needs of children. //2008//

/2009/ With increased medical costs and the identification and treatment of rare medical conditions, continual collaboration with other agencies has been essential to providing the needed services, while maintaining the MHCP budget.

During FFY 2008, three work groups were established to develop strategies specific to three priority needs: preterm birth/low birth weight; overweight among children and women of reproductive age; and transition to adult services for CYSHCN. The intent of these work groups were to better focus Title V attention on fewer priorities, and deferring to other programs and funders, when doing so would more efficiently address a priority

need. For instance, Nebraska's Strategic Prevention Framework State Intervention Grant (SPF SIG) has completed planning for and is investing resources towards the prevention of underage and binge drinking. Thus, SPF SIG was targeting Nebraska's MCH priority need to reduce alcohol use among youth. Other programs and their associated funding sources were similarly addressing unintentional injuries, prevention of child abuse and neglect, and MCH tobacco use.

The three work groups conducted problem analyses, researched current literature, and developed logic models. The recommended strategies developed by the CYSHCN work group addressing transition services will be considered by the Medically Handicapped Children's Program in its planning and program development. The recommended strategies of the preterm birth/low birth weight workgroup and the overweight among children and women work group became the primary basis for the competitive RFA for community-based MCH projects issued in May 2008.

Narrowing down this RFA to fewer priorities was seen as essential to maximizing the potential of the Block Grant. Investing small amounts of funds to address several needs was seen as less likely to improve outcomes. In addition, the logic models developed for preterm birth/LBW and overweight women and children yielded very similar and compelling themes: life course approaches to improving outcomes and eliminating disparities, including pre and interconception health; population-based, primary prvention and wellness models; the importance of community-wide and system level change; and a focus on social determinants of health and health equity. Building community-level interventions around these themes was determined to be important in maximizing Title V as a funding source. //2009//

B. State Priorities

Nebraska completed its most recent comprehensive needs assessment in 2005. Ten priority needs were identified. Below is a description of each priority need, NE's capacity and resource capability to address each, and relationships to national and state performance measures. It must be noted that community-based projects addressing priority needs will NOT be known until on or after August 15, 2005. Mid and long range planning for state-level strategies will be initiated early in FFY 2006.

/2008/The Office of Family Health chartered three workgroups that are actively developing strategies for three priorities. See below.//2008// ***/2009/See update in Sec. IV A. //2009//***

/2007/ Eight community-based projects were identified through a competitive process conducted in FFY 2005. Subgrants were awarded for an initial nine-month period beginning January 1, 2006, with two additional 12-month award periods possible, assuming acceptable performance and availability of funding. //2007//

1. Reduce the rates of overweight women, youth, and children by increasing participation in sufficient physical activity and improving nutrition.

Following national trends, increasing rates of overweight was identified as a priority need across all MCH populations. Taking the lead in addressing this need has been Nebraska's Cardiovascular Health Program. In collaboration with the Office of Family Health's School and Child Health Nurse Coordinator, the Cardiovascular Health Program collected and analyzed BMI data for 40,154 students in K-12 from 235 schools for the 2002/2003 academic school year. The study report, published in June 2004, provided excellent baseline data for the assessment of overweight among Nebraska children as part of the recent needs assessment. In addition, the Cardiovascular Health Program led the development of the Nebraska Physical Activity and

Nutrition State Plan, released in April 2005. This plan lays out a comprehensive set of goals, strategies and objectives to be used for intra and inter-agency collaborations for the next 5 years. The Office of Family Health has taken the lead in addressing the objective for increasing supports for breastfeeding, through an initiative that was launched in January 2005. The Office will continue to work with both the Cardiovascular Health Program and the Office of Women's Health in promoting VERB(r) and will help the Cardiovascular Health Program launch the Youth Physical Activity and Nutrition Lifestyle Modification Rx for use in both school and health care settings.

/2007/ Four of the eight community-based projects address this priority through related activities.//2007//

/2008/ A workgroup was formed in 2007 to develop targeted MCH strategies to address this priority. Work will continue into early 2008.//2008//

Of the National Performance measure, only NPM #11, percentage of mothers who breastfeed their infants at hospital discharge, relates in any way to this priority needs. Thus, a new State Performance Measure # 1 has been chosen for 2006: percent of women (18-44) with healthy weight.

2. Reduce the percent of women of child-bearing age, particularly pregnant and post-partum women, and adolescents who use tobacco and reduce the percent of infants, children and youth exposed to second hand smoke

Tobacco use and exposure to second hand smoke were identified as significant factors impacting a wide range of health outcomes for MCH populations. Nebraska has a strong Tobacco Free Nebraska program that has been an ongoing partner with the Office of Family Health. In 2002 and 2003, in collaboration with Tobacco Free Nebraska, the Office of Family Health developed tobacco cessation materials for women of child bearing age and their health care providers. In addition, Family Health subgranted funds to community-based organizations to develop local capacity for perinatal tobacco cessation efforts. These materials and the subgranting efforts were financed with tobacco settlement funds. The Office of Family Health will continue to build on this working relationship with Tobacco Free Nebraska in promoting tobacco prevention and cessation. For instance, Family Health is participating in the development of a tobacco cessation state plan, being lead by Tobacco Free Nebraska.

/2007/ Of the eight community-based Title V funded projects, three report tobacco prevention/cessation activities. //2007//

No National Performance Measures relate to this priority need. Nebraska therefore has selected for 2006 SPM # 2, percent of women of child --bearing age who report smoking in the past 30 days.

3. Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy.

In order to improve overall outcomes for infants, this cluster of events was identified as a priority need. Nebraska Title V/MCH Block Grant funds have long invested in services for pregnant women, including adolescents. These services range from prenatal care, to home visitation, to outreach and translation services. It is anticipated that such services will again be included in the array of local projects funded in FFY 2006 through FFY 2008. In addition, the Office of Family Health has and will continue to work with local initiatives, such as "Baby Blossoms" in Omaha/Douglas County, and its member programs, such as Omaha Healthy Start. In addition, the Office continues to work with the Medicaid Managed Care program on a prenatal care quality improvement initiative. Yet much more needs to be accomplished, particularly related to pre and interconception risks. As identified by Omaha's Baby Blossoms members using Perinatal Periods of Risk methodology, maternal health is key to improving birth outcomes. Over the next year,

additional strategy development and partnership formation will be pursued to build capacity in this area.

/2007/ Five community-based Title V projects include this priority among those to be addressed. //2007//

/2008/ A work group was formed in 2007 to further analyze this priority and develop strategies for reducing preterm and lowbirth weight. Work will continue into early 2008, with the completion of an action plan.//2008//

National Performance Measures #15, percent of very low birth weight infants, #17, percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates, and #18, percent of infants born to pregnant women receiving prenatal care beginning in the first trimester all relate to this priority need. In addition, SPM #5 has been selected for 2006, percent of premature births, and SPM #6, rates of infant death to adolescent mothers (age 15-17).

4. Reduce the rates of hospitalizations and deaths due to unintentional injuries for children and youth.

This priority was also identified in the 2000 needs assessment, with unintentional injuries being the major cause of morbidity and mortality among Nebraska children. Nebraska's capacity to address this issue has its leadership within the Nebraska Injury Prevention Program, Office of Disease Prevention and Health Promotion. This program has long fostered and supported Safe Kids coalitions across the state, and has a strong motor vehicle safety component. The program also plays a key role in monitoring and analyzing injury data, releasing the Nebraska Injury Surveillance Report in August 2004. In addition, Nebraska's Emergency Medical Services for Children program has been an active provider of injury prevention information across the state. The Office of Family Health will continue its close working relationship with these programs, and pursue new endeavors. For instance, the Office of Family Health is leading a Safe Sleep initiative, and both the Injury Prevention Program and EMSC staff are participating in this effort.

/2007/ Four community-based projects are actively addressing unintentional injuries. //2007//

National Performance Measure #10 will be useful in measuring progress in reducing motor vehicle associated injuries. In addition, a new SPM #9 has been chosen for 2006, hospitalization for unintentional injuries (per 100,000) for children and adolescents (age 1-19).

5. Reduce the number and rates of child abuse, neglect, and intentional injuries of children.

Intentional injuries were combined with unintentional injuries as a priority need identified through the 2000 comprehensive needs assessment. The identification of prevention of child abuse, neglect and intentional injuries as a separate priority in 2005 marks a major shift for public health in Nebraska. Abuse and neglect, as well as youth suicide and homicide, have traditionally been seen as child welfare, behavioral health, and criminal justice issues. As a priority for MCH, new opportunities emerge for primary and secondary prevention efforts. Over the next several months, the Office of Family Health will be working with the HHS Protection and Safety, Prevent Child Abuse Nebraska, and the Foundation for Children and Families in developing a child abuse prevention plan. Development of the plan will include an analysis of best practices and engagement of community stakeholders. Concurrently, Nebraska's Injury Prevention Program is working with other stakeholders to develop plans related to youth suicide prevention. These and other collaborative efforts will add significantly to our state's capacity to address this priority.

/2007/ Three community based projects are carrying out activities to address this priority. LB 994 passed in 2006 was accompanied by a State General Funds appropriation for shaken baby syndrome prevention materials and activities, in combination with SIDS risk reduction. //2007//

/2008/ During 2007, a Sexual Violence Prevention Advisory Committee was formed, with the Title V/MCH Director as a member. This group will provide greater insight into child sexual assault and primary prevention strategies. The Child Abuse Prvention Plan, described above, was issued in 2006, and the Title V/MCH Director as a member of the Prevention Partnership is participating in implementation activities.//2008//

National Performance Measure # 16, rate of suicide deaths among youth aged 15 -- 19, relates to this priority, but does not provide a measure of child abuse and neglect. Therefore SPM # 10, has been selected, hospitalization for intentional injuries (per 100,000) for children and adolescents.

6. Reduce the rates of infant mortality, especially racial/ethnic disparities.

This need was also an identified priority in 2000. Though overall infant mortality rates have shown some improvement over the past 5 years, there is still work to be done to meet 2010 objectives and much more work to eliminate racial/ethnic disparities. The work and capacity development described for Priority Need #3 above is also relevant to this priority. In addition, a continued focus will be maintained on postneonatal deaths, particularly sleep associated infant deaths. The Safe Sleep Initiative, launched in April 2005, has brought together a wide range of stakeholders to develop a shared understanding of sudden, unexpected infant deaths, and members of the initiative's steering committee are currently developing a report of recommendations on prevention messages and system strategies. This state level effort will coordinate closely with that of Baby Blossoms, the Omaha area perinatal collaborative.

/2007/ This priority is being addressed by seven of the eight community-based projects in some aspect of their activities. //2007//

/2008/ Upon completion of the Preterm/Low Birth Weight work group activities, an infant mortality work group will be formed. This work group will further explore IMR disparities and identify best and promising practices for addressing these disparities. Preterm births, along with SIDS, are the major contributers to IMR disparities in Nebraska.//2008//

No National Performance Measure provides an adequate gage of progress, particularly related to disparities. Therefore SPM # 7, incidence of confirmed SIDS cases (per 1000 live births) among African American and native American infants, and SPM #8, percent of African American women beginning prenatal care during the first trimester, have been selected for 2006.

7. Reduce alcohol use among youth.

Youth alcohol use was combined with tobacco and other drug use as a priority need in 2000. The separate identification of alcohol use as a high risk behavior among Nebraska youth highlights its contribution to a wide range of poor health outcomes, including motor vehicle injuries and mortality. The Office of Family Health had been an active partner in the State Incentive Cooperative Agreement (SICA), a state/federal partnership to reduce substance abuse among youth ages 12 to 17. But much of the collaborative work thus far has focused on identifying risk and protective factors among Nebraska youth. Much needs to be done to develop public health capacity for alcohol prevention. We can learn from successes achieved through Tobacco Free Nebraska, but an ongoing challenge will be garnering enough resources to invest in this effort. Identifying key partners will be a major initial step in building this capacity.

/2007/ Alcohol use among youth is an identified priority for three of Nebraska's community-based Title V funded projects. In addition, the Adolescent Health Program in the Office of Family Health has launched "Nebraska Partnerships for Positive Youth Development" as a strategy for addressing alcohol and other risk behaviors among youth. //2007//

None of the National Performance Measures relate to this need. A SPM that Nebraska has been

tracking the past 5 years will be continued as SPM # 4 in 2006, percent of teens who report alcohol use in the past 30 days.

8. Increase capacity of community-based medical home providers to detect and refer for treatment women, children, and youth with emotional and behavioral health conditions.

Key to the identification of this priority was the CSHCN SLAITS data for Nebraska, which revealed access to behavioral health services to be a significant problem for special needs children and their families. This observation, along with the NE HHS System's extensive work in behavioral health reform, places behavioral health among Nebraska's MCH/CSHCN priorities for the first time. Nebraska's capacity to address this need has been significantly improved through multiple efforts underway, including: the strategic plan being developed as part of Nebraska's Early Childhood Comprehensive Systems grant; the SAMHSA-funded State Infrastructure Grant; and the recently awarded perinatal depression grant.

/2007/ Nebraska's ECCS and SIG grants are now actively addressing this priority, and two contractors have been selected to carry out perinatal depression activities. //2007//

/2009/ EDN Services Coordinators were trained on the medical home model and have utilized this model in serving CAPTA families. This reduces ER visits and the use of County Health Centers for the provision of shots.//2009//

/2008/ A training for all service coordinators has been planned for the next reporting year regarding infant mental health. Speakers, Paula Zeanah and Julie Larrieu, from Tulane University School of Medicine will present a two day workshop on their multi-year research project. Workers will gain knowledge on identifying characteristics of children with various levels of mental health issues. //2008//

/2009/The Infant Mental Health Conference was held in Omaha and Kearney in May 2007. Paula Zeanah, Ph.D., M.S.N., is a clinical psychologist and a pediatric nurse and is an Associate Profess of Psychiatry and Pediatrics at the Tulane University School of Medicine. Julie Larrieu, PH.D., is a developmental and clinical psychologist, and is an Associate Professor of Psychiatry and Pediatrics at the Tulane University School of Medicine. They provided 2-day training. On the first day of training, they focused on "Psychopathology in Infancy" and on the second day, Dr. Zeanah provided a presentation on "A Relational Perspective on assessment, Intervention, Services, and Self" and Dr. Larrieu provided a presentation on "Therapeutic Intervention for Young Children and Their Caregivers: Child-Parent Psychology." The conference was designed to coordinate services through collaboration and heighten awareness of Infant Mental Health wellness, which referred to activities and experiences that encourage healthy social and emotional development of children in their first few years of life. Mental health professionals and those trained to work with children and families were able to benefit from specialized training that addressed IMH wellness. EDN Services Coordinators attended this conference and MHCP workers received all the materials from the conference.

In 2007, the Infant Mental Health Conference was a success and now EDN plans to begin having yearly conferences on Infant Mental Health Conference.//2009//

NPM # 16, rate of suicide deaths among youth aged 15 -- 19 offers a limited measure of progress in addressing this need. To further assess our work, SPM # 3 has been selected, percent of women (age 18-44) who report mental health not good 10+ days of past 30.

9. Increase capacity of Title V Programs for Children with Special Health Care Needs to serve increased numbers of children meeting medical and financial eligibility criteria and who are uninsured or underinsured.

In this time of increasing cost of medical services it is difficult to increase the number of families served without increased finances. We are maintaining our services. As Medicaid reform continues we may see a need to tighten or limit the number of clinics or services we are able to provide.

/2007/ Two of the eight community-based Title V funded projects are providing enabling services to the CSHCN population. //2007//

/2009/ Connect reports indicate a slight decline in the number of MHCP clients covered under Medicaid and private insurance this year. This is due to a modification of the insurance fields on the Connect database in order more accurately track the number of CYSHCN and their insurance coverage. The modification will provide additional information regarding insurance coverage. The system will record the specific name and address of the insurance company providing coverage, along with the insurance coverage period. This will provide current, accurate, and detailed insurance coverage for each MHCP client. It will allow us to track fluctuations in private insurance coverage and increase the ability to track and report data in this area.//2009//

National Performance Measure #4, percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for services they need, is directly related to this priority.

10. Build capacity of Title V programs for Children with Special Health Care Needs to provide transition medical and dental clinics for youth with special health care needs 14-21 years.

Through a federal Centers for Medicare and Medicaid Services System Change grant, Nebraska will develop and pilot transition medical and dental clinics for youth with special health care needs. The clinics will incorporate education for resident physicians on the disability related medical conditions that will advance as the youth ages to adult medical care. This will increase the number of physicians familiar with special health care needs and increase the number of knowledgeable physicians in communities to provide a "medical home."

/2008/ The portals grant is providing education to faculty of family practice residents regarding disability and CSHCN need for a medical home. Curriculum has been developed and will be distributed to facility at the University of Nebraska Medical Center. //2008//

/2009/ We have increased the capacity of physicians, continue these as transition clinics and A Youth Advisory Council.//2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	99.8	100.0	98.7	98.8	100.0
Numerator	26008	30	153	167	185
Denominator	26067	30	155	169	185
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2005
the two infants that who tested poitive at birth and did not recieve services expired. Of the 153 that did get follw-up services only 26 required further treatment.

a. Last Year's Accomplishments
The Nebraska Newborn Screening & Genetics Program managed mandated screening for 8 diseases (Biotinidase Deficiency, Congenital Adrenal Hyperplasia, Congenital Primary Hypothyroidism, Cystic Fibrosis, Galactosemia, Hemoglobinopathies MCAD & PKU) during this reporting period, and universal (offered to every newborn, but consent required) for another approximately 26 amino acid, organic acid and fatty acid disorders, via the "supplemental" screen. All newborn specimens from Nebraska newborns were sent to Pediatrix Screening Laboratory. As a result of a negotiated rate of $35.75 for testing and NBS fee (mandatory only, or mandatory plus supplemental) greater than 97% of newborns benefited from the full amino acid and acylcarnitine profiles provided at Pediatrix Screening Laboratory.

The numbers screened can only be reported by calendar year. In 2007 Nebraska had 27,107 births reported (preliminary numbers) to the Newborn Screening Program (preliminary numbers) of which 27,013 were screened. Ninety four were not screened as they expired by 48 hours of birth. Parents of 97.6% of newborns consented to and their newborns received the supplemental screen. Seventy eight of the 80 home births reported to the program were screened. The Two who were not screened expired.

Newborns with disorders were identified and treated early to prevent mental retardation, physical disabilities and disease, and infant death. The following list identifies which conditions were picked up on the screen and for whom early intervention was initiated: 4 newborns with partial biotinidase deficiency (treated); 1 newborn with congenital adrenal hyperplasia;12 newborns with cystic fibrosis; 16 newborns with congenital primary hypothyroidism; and 1 newborn with sickle cell disease, 1 with hemoglobin-C disease, 1 with Beta Thalassemia Major, 1 with Sickle Beta Thalassemia. From the "optional" supplemental newborn screening panel, babies were found with these conditions and treatment was initiated: 1 with Glutaric Acidemia Type I;1 with Methylmalonic Aciduria; and 2 with Transient Tyrosinemia.

In 2007, the Nebraska Newborn Screening Advisory Committee recommended that the program make the conditions screened by tandem mass spectrometry in the amino acid and acylcarnitine profiles mandatory, instead of optional. This was in consideration of the American College of Medical Genetics (ACMG) recommendation for a core panel of 29 conditions, which was endorsed by the Secretary's Advisory Committee on Heritable Diseases and Genetic Conditions in Newborns and Children (ACHDGDNC), and endorsed by the National March of Dimes. The Department approved proceeding with regulation revisions during this time, and the public process to revise regulations took place. Regulations were approved and signed by the Governor in late December 2007, with implementation planned for July 1, 2008.

The program continued its continuous quality improvement monitoring and action (usually through educational strategies). One special QA projects was initiated with analysis of individual hospital turn around time data, a survey of best performers, and distribution of "best practices" models along with special notification of the hospitals in the bottom 25%ile. A second special QA project focused on the quality of the specimens themselves, due to a noticeable increase in the % of unsatisfactory specimens being submitted to the newborn screening laboratory during the last

quarter of 2007.

The program implemented the Newborn Screening Advisory Committee's and the Early Hearing Detection and Integration (EHDI) Advisory Committee's recommendation for incorporating/integrating testing of dried blood spots for genetic causes of hearing loss such as Connexin 26, CMV, Pendred and mitochondrial. This involved the EHDI program distribution of education to physicians regarding the short window of time they have available to retrieve blood spot specimens for CMV and other genetic testing, and incorporating a letter into the EHDI follow-up procedures advising physicians of the recommendation and procedure to retrieve the newborn blood spot.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screened, refered, tracked & facilitated treatment for 8 required disorders and 20+ optional screened disorders as per Neb. Rev. Stat. 71-519 to 524.			X	
2. Continued quality assurance activities with hospitals, contracted laboratory and referral networks.			X	
3. Integrated testing of dried blood spots for genetic causes of hearing loss.			X	
4. Provided professional and parent education, including maintenance of web.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Newborn Screening and Genetics Program now screens all newborns for 8 required disorders (10 if one counts hemoglobinopathies as sickle cell, sickle hemoglobin C, and sickle beta Thalassemia), and universally offers to all parents supplemental screening for another approximately 20+ disorders via tandem mass spectrometry. Education, NBS testing, follow-up, referral and treatment and quality assurance activities continue. Updates to all parent education and professional education materials (including the web page) will occur by July 1, 2008. Planning to implement long term follow-up data collection and analysis will begin for the metabolic disorders screened, in accordance with a Heartland Regional Collaborative project.

c. Plan for the Coming Year

The newborn screening program staff will prepare professional and parent education materials and distribute these Statewide to appropriate health care professionals and hospital personnel in order to implement the changes to the regulations by July 1, 2008. Staff will continue to work with the new private provider of newborn screening laboratory services following their award of the competitively bid contract. The all hazards preparedness plan for newborn screening will be updated. Enhancement of the State's newborn screening quality assurance system will be evaluated, particularly for short term and long term follow-up and the education elements of the system, and as appropriate, plans to implement enhancements will be developed. Opportunities for integrating newborn screening data with other child health data systems for the purpose of improved public health surveillance, and improved individual health outcomes will be monitored.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	0	70	70	67.7	69.1
Annual Indicator	66.4	66.4	66.4	66.4	65.7
Numerator	326	326	326	326	
Denominator	491	491	491	491	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	67	68.4	69.7	71.1	72.5

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2009/ Meth Training for MHCP workers was done Spring 2006. We conducted training for MHCP workers and Service Coordinators on identification and precautions the use of meth. These workers often meet families in the home environment and there was concern with the growing number of meth users especially in the rural communities. The Nebraska state patrol officer conducted the training that consisted of the history of meth, its chemical structure, and observable characteristics of those using this drug.

The web based Medicaid Waiver training for Services Coordinators was done and implemented July 2006. This training was to ensure the necessary knowledge regarding services to children with special health care needs. The web based training is monitored by the Services Coordinators' Supervisor and Central Office Support staff.

Implementation of the CSHCN computerized tracking system, CONNECT, was modified in several ways. These modifications included:
1. Development of billing system for Medically Handicapped Children's Program (MHCP).
2. Functions and roles for each level of user were created, tested and distributed throughout the statewide service areas.
3. Procedures for the payment process were established, through the use of a three tier payment system.
4. This newly designed billing system was linked to automatically upload to the State of Nebraska's payment processing system which sends reimbursement to providers/clients.

//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted training for MHCP workers and Service Coordinators on identification and precautions the use of meth. These workers often meet families in the home environment and there was concern with the growing number of meth users especially in the ru				X
2. The web based Medicaid Waiver training for Services Coordinators was done and implemented July 2006. This training was to ensure the necessary knowledge regarding services to children with special health care needs.		X		X
3. The CSHCN computerized tracking system, CONNECT, was modified in several ways. These modifications included development of billing system for Medically Handicapped Children's Program (MHCP).				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/School districts for EDN to track to movement and services for children in early intervention by school district are being added to our computerized database CONNECT. This will allow our department/HHS to keep closer track the number of verifications by district and provide information to our federal partners Office of Special Education programs (OSEP).

CONNECT System is being modified to track the history of families private insurance coverage, changes, and usage.

A additional modification to the system is to automatically close any authorization upon the closing of a file.//2009//

c. Plan for the Coming Year

/2009/EDN Services Coordinators will begin data collection through Developmental TIPS for children that have been part of this program and are now entering first grade.

Research the possibility of computerizing the overall MHCP QA system

Part C of the IDEA which in Nebraska is the Early Development Network, a collaborative relation between the Department of Health and Human Services and the Department of Education will complete a family survey to determine the satisfaction with services coordination and their educational services. //2009//

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	0	55	55	55	56.1
Annual Indicator	53.8	53.8	53.8	53.8	54.2
Numerator	706	706	706	706	
Denominator	1313	1313	1313	1313	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	55.2	56.4	57.5	58.6	59.8

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2009/ Other states Medical Home projects were reviewed for components to be potentially be utilized in Nebraska.

MHCP staff were trained on the transition project in order to refer families to the transition clinics.

Monthly video training conferences were held funded through the CMS Portals grant along with UNMC physicians regarding disability related topics.

In the previous reporting period, we described the Telemedicine pilot project with the University of Nebraska Medical Center in Omaha, the Educational Services Unit and the Hospital in Scottsbluff along with the Children with Special Health Care Needs Program, the Special Education Division of the Nebraska Department of Education and the Munroe Meyer Institute (a LEND grant recipient) of the University of Nebraska Medical Center had

entered into an agreement to begin. The Specialty Services Clinics contract between the University and the CSHCN Program includes the wording "…to determine protocols, rates and methodology to begin a series of pilot/demonstration telemedicine sessions that are efficient in time and costs to families and medical/paramedical staff." This pilot has been successful and will be an essential element in the transition clinics described above.

Participation in a multi agency work group regarding modifications to our CSCHN medical home program. Coordination with Boys Town, Family Health and MCH CSCHN work together in this endeavor. //2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Other states Medical Home projects were reviewed for components to be potentially be utilized in Nebraska.				X
2. MHCP staff were trained on the transition project in order to refer families to the transition clinics.				X
3. Monthly video training conferences were held funded through the CMS Portals grant along with UNMC physicians regarding disability related topics.				X
4. The Telemedicine pilot project with the University of Nebraska Medical Center in Omaha, the Educational Services Unit and the Hospital in Scottsbluff along with the Children with Special Health Care Needs Program, the Special Education Division of th	X			
5. Participated in a multi agency work group regarding modifications to our CSCHN medical home program and oordinated with Boys Town and Lifespan Health Services projects (ECCS, EHDI, and NBS).				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/ We are collaborating with Boys town through a HRSA grant to develop Medical Home services for children with special health needs.

Staff will attend trainings on Medical Home models. //2009//

c. Plan for the Coming Year

/2009/MHCP workers and EDN Service Coordiators will be trained through Boys town on creating medical homes and physicans willing to participate in this demonstration.

EDN Services Coordinators will apply their knowledge of Medical Homes model in the provision of CAPTA services.//2009//

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective		65	65	65	66.3
Annual Indicator	63.5	63.5	63.5	63.5	65.9
Numerator	719	719	719	719	
Denominator	1133	1133	1133	1133	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	67.2	68.6	69.9	71.3	72.8

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2009/ As the number of children without adequate or capitated insurance rises we strive to continue to meet the increased medical needs by leveraging all available funds. //2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. As the number of children without adequate or capitated insurance rises, strive to continue to meet the increased medical needs by leveraging all available funds.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

/2009/ We have modified our database to track our families private health insurance coverage.

We are examining data on children with special health care needs, that are receiving Medicaid but not in a program with case management staff, to determine if coordination would decrease Medicaid utilization while improving the services to the families. //2009//

c. Plan for the Coming Year

/2009/ Medicaid will implement a care coordation system for children with high medical needs and Medicaid expenitures in order to contain costs and provide necessary services.//2009//

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective		80	80	81.4	83
Annual Indicator	79.8	79.8	79.8	79.8	91.9
Numerator	327	327	327	327	
Denominator	410	410	410	410	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	93.7	95.6	97.5	99.4	100

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

/2009/ Conducted a file review that indicated families that MHCP services were easily accessed.

We conducted a Family Experience Survey for children with special health care needs under Service Coordination. //2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted a file review that indicated families find that MHCP services were easily accessed.				X
2. Conducted a Family Experience Survey for children with special health care needs under Service Coordination.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/ The HHS Website has been redesigned to provide a more user friendly, easier access format. Families may also utilize on-line service applications for some programs.

A Youth Panel Listserve has been developed on www.Answers4Families.org to discuss transitional issues and problem solve.

Part C of the IDEA which in Nebraska is the Early Development Network, a collaborative relation between the Department of Health and Human Services and the Department of Education has completed a family survey to determine the satisfaction with services coordination and their educational services. We had a 46% return rate with families reporting satisfaction in their services.//2009//

c. Plan for the Coming Year

/2009/Part C of the IDEA which in Nebraska is the Early Development Network, a collaborative relation between the Department of Health and Human Services and the Department of Education, will complete a family survey to determine the client's satisfaction with services coordination and their educational services.

The Youth Panel will be broaden to incorporate all aspects of transition into adulthood.

The MHCP Manager will meet with MHCP workers to discuss the development of a process that will incorporate a revised user friendly MHCP Clinic evaluation form.

Develop an Advisory Committee involving clients and/or their family members to develop an overall process for the new MHCP transition clinics, and develop a standardized referral form, assign an navigator to the project, provide client consultation, develop

general final reports, and begin scheduling the MHCP transition clinics. //2009//

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective		10	10	5.2	5.3
Annual Indicator	5.1	5.1	5.1	5.1	54.4
Numerator	118	118	118	118	
Denominator	2314	2314	2314	2314	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	55.4	56.6	57.7	58.8	60

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2009/ Faculty of UNMC has developed a curriculum that will be incorporated into the education of family physician through their residence program. This has and will increase the number of physicians familiar with disability related issues and therefore increase their comfort level in accepting individuals with disabilities in their practices.

We worked with 18 youth through the transition clinic to develop a plan to meet their medical, educational, and employment needs as they transition into adulthood.

In 2004 Nebraska was awarded a Center for Medicare and Medicaid Service (CMS) grant "EPSDT Portal to Adulthood for Transitioning Youth". Through this grant we established a multi-disciplinary team in a clinic setting for youth 16-19 years old. The team consists of a Pediatrician, a Psychologist, Nutritionist and a Family Coordinator. We attempted to incorporate a Pharmacist to examine prescriptions of each youth and discuss the use and care of the drug as it may relate to their particular disability. However, it is sometimes

difficult to have Pharmacists and Physicians reviewing each others decisions. The Pharmacist should have been included in the original planning and writing of the grant application. Pharmacy was an addition after our award.

Nebraska's original hypothesis was that many adults with disabilities would still be seen by pediatricians well into adulthood because there weren't available practioners and the disability awareness of the pediatrician. Often screenings and typical adult testing didn't occur because the pediatricians don't have a need to address issues. Therefore we wanted to build the capacity of physicians familiar with disability issues of youth/adults. We contracted with the University of Nebraska Medical Center (UNMC) which met with the faculty of Family Physicians and incorporated the transition clinic into the resident's rotation. UNMC developed curriculum to be used in the training of Family Practice resident education regarding transition and disability issues. As the residents graduate and move across the state and begin their private family practices they will build that capacity of informed physicians regarding disability.

We also added a benefits analysis piece to address the issue of work incentives and employment options for youth wanting to pursue that dream of independence and typical life choices.

We implemented a Youth Advisory Council (YAC) to review documents created by UNMC. It took a great deal of time to establish this YAC, therefore they were unable to be the peer mentor we had originally planned.

Recommendations if a state wanted to duplicate our efforts:
- Determine all components of the clinic prior to implementation
- Determine the target population and involve the workers associated with that population
- Market to families regarding the importance of transitioning and planning
- Determine sustainable funding source to encourage participation

We hope to fund with our Title V CSHCN funds. We had planned to amend our Medicaid Waiver to incorporate this as a service. However, due to administrative changes we were unable to include transition in the Waiver. Had we planned to use Title V dollars in the beginning our demonstration may have been designed more broadly and included more life issues such as housing, personal assistance and career input. This is our plan now. //2009//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Faculty of UNMC developed a curriculum that will be incorporated into the education of family physician through their residence program. This has and will increase the number of physicians familiar with disability related issues and therefore increas				X
2. Worked with 18 youth through the transition clinic to develop a plan to meet their medical, educational, and employment needs as they transition into adulthood		X		
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

/2009/ A youth panel specializing on adolescent transition issues was established in the months to come.
Work under the CMS Portals grant provided and fund benefits analysis for youth and adults.
Five youth were provided information on the use of work incentatives for youth receiving SSI/SSDI.//2009//

c. Plan for the Coming Year

/2009/We will use the information obtained from the CMS Portals grant to continue the transition services by developing and implementing transition clinics with expanded focus under MHCP. These clinics will include information and guidance regarding education, employment, housing, as well as medical services needed for each individual to transition into adulthood living as independently as they choose.

Meet with the University Administration regarding their future role in MHCP transition clinics with expanded services.

Using HRSA materials setup MHCP transitional clinics and expand their use to other programs (ie waiver workers, EDN Services Coordinators, and other specific case workers)//2009//

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	90	90	83.9	85.4	86.9
Annual Indicator	77.9	82.3	89.1	81	81.9
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	83.5	85.2	86.9	88.6	90.4

Notes - 2007
Data is Q3/2006-Q2/200. The entire 2007 data has not been released by CDC.

Notes - 2006
Nebraska relies on NCHS National Immunization Survey (NIS) for current vaccination estimates. Num and Denom are not provided because they are unknown.

Notes - 2005
2005 data has not been released by CDC.

a. Last Year's Accomplishments
The Nebraska Immunization Program is located within Lifespan Health Services. Primarily funded through the National Immunization Program (NIP) at the CDC, this program administers the 317 and Vaccine for Children (VFC) funds, as well as a Perinatal Hepatitis B project. In FFY 2007, the program supported 86 counties with public clinics across the state, 86 counties with public VFC providers and 218 VFC private providers. The Program also administered, through a subgrant, an immunization registry that includes all public immunization clinics except those in Lancaster County. Nebraska participates in the Hallmark Card program (a card signed by the Governor and First Lady and sent to the parents of all newborns with an immunization message).

Title V funds help support the costs of the immunization registry, which serves all public clinics except those in Lancaster County.

The administration of a 4th dose of DtaP impacted rates for the full immunization series.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported public immunization clinics and private VFC providers across the state.			X	
2. Maintained current immunization registry in public immunization clinics and developed new immunization information system			X	X
3. Continued participation in Hallmark Card program.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Nebraska Immunization Program continues to support 86 counties with public immunization clinics and 218 private VFC providers. The immunization registry continues to be in place, with a new web-based registry currently being set up. Training is underway, and pilot sites will begin later this summer. Transfer of data from the old system to the new system is schedulded for the fall of 2008.

A modest allocation of Title V funds continues this year to the Immunization Program, as partial support for the registry.

c. Plan for the Coming Year
Implementation of the web-based mmunization registry will be completed in the public sector, and private providers will then be added. Normal immunization-related activities will also continue. Activities to increase use of adult Hepatitis B vaccine will be initiated.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	18.5	18	17.5	17.7	15.9
Annual Indicator	18.5	17.8	18.1	16.3	17.0
Numerator	696	670	690	616	644
Denominator	37675	37702	38097	37844	37863
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	16.6	16.3	16	15.6	15.3

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

Notes - 2005
Provisional data due to birth certificate conversion in 2005. Denominator is a census projection. Targets are based on 2% yearly improvement.

a. Last Year's Accomplishments
The Adolescent Health Programs' 2007 activities included continued promotion and marketing of Positive Youth Development as a framework for adolescent health programming. A statewide web based survey was conducted to help identify youth development organizations and activities across the state. A state team comprised of members from Lifespan Health, Douglas County Health Department and Region V Behavioral Health attended a roundtable training event sponsored by AMCHP/CityMatCH specific to science-based approaches to teen pregnancy prevention. Lessons learned will be incorporated into the youth development model and promoted at the 2008 Public Health Association of Nebraska (PHAN) annual conference. A workgroup was convened for the purpose of completing a problem analysis specific to reducing preterm and low birth rates in Nebraska with attention to adolescents. Intervention pathways were identified, and logic models completed for preconception health, community supports and health literacy.

Nebraska's Abstinence Education grant implemented 9 sub grants in selected sites across the state. The program facilitated a sub grant symposium with training and updates on programming activities available. Additional curriculum training and workshops were held at selected sights. Program marketing efforts centered on publication of a quarterly newsletter and televised PSAs running during the Girls and Boys State Basketball tournaments.

Nebraska Reproductive Health Title X Program was awarded a Title X HIV Supplemental Grant from the Office of Population Affairs for the Delegate, Central Health Center, to implement the 2006 CDC HIV Testing Guidelines. With this award Central Health Center has integrated HIV testing as a part of every client's routine visit, with an opt-out option. With this integration adolescents are included in this testing and the data collected will give a cursory evaluation of the HIV risk/prevalence in central Nebraska. This project will allow a nationwide evaluation of the value of HIV testing integration as a part of routine healthcare.

The Nebraska Reproductive Health training program offered a conference call session on "Marketing to Adolescents". The call included updates from individual Delegates and a sharing of "What Works".

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided comprehensive reproductive health services through the NE Reproductive Health Program, including outreach and community education for adolescents.	X		X	
2. Maintained abstinence education programming and coordinated with community-based stakeholders.			X	
3. Continued to develop and promote Nebraska Partnerships for Positive Youth Development.				X
4. Participated in AMCHP/CityMatCH teen pregnancy roundtable, developing capacity to implement evidence-based prevention strategies.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Work continued on developing the materials and message for the team promoting science-based approaches to teen pregnancy prevention. The team will also promote community-based youth development efforts as identified in the Nebraska Partnership for Positive Youth Development (NPPYD) survey conducted in the previous grant year.

Abstinence Education activities continue though there were no active sub grants. A community development model was implemented in Wahoo, Nebraska and activities occurred in two communities targeted in previous grant years. A new workshop specific to teen dating violence was implemented in four sites across the state.

Nebraska Reproductive Health staff is working collaboratively with a post-graduate student on a research project to look at trends experienced by Nebraska Reproductive Health Title X Delegates in relationship to services provided to uninsured, underinsured, number of Medicaid served, poverty levels of clients, client demographics over time, etc. In addition, a historical look at Title X funding, lack of other sources of funding, lack of a Nebraska family planning Medicaid waiver, increasing costs of contraceptives, and the increasing costs of providing services are to be evaluated. The analysis will assist in long-range planning and document the barriers that exist for the Title X Delegates to provide equitable, quality services to Nebraska's low income populations that experience disparate health outcomes, including adolescents.

c. Plan for the Coming Year

The Adolescent Health Program will continue to promote science-based approaches to all youth-related health issues with specific attention to teen pregnancy prevention. Youth Development principles and practices will be incorporated into program activities and messages. Abstinence Education will continue to be promoted as availability of federal funding allows. Emphasis will be

placed on relationship skills and teen dating violence. A blueprint for action will be developed as a means of guiding future program efforts with specific attention given to developing strategic plans for identified teen health issues including teen pregnancy and births.

During the next fiscal year Nebraska Reproductive Health will be working with staff from the National Cancer Institute to develop outreach based on social marketing methodologies. The social marketing will target select demographic groups for cervical cancer screening and HPV vaccine promotion by using Consumer Health Profiles for individual Delegates and identified service areas. Increased screening will be documented by comparing prospective screening numbers with a retrospective evaluation of screening participation. This outreach will improve access to services among adolescents, not only for cervical cancer screening and HPV vaccine, but also for other family planning services.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	17	17	45.7	46.8	47.8
Annual Indicator	0.0	44.6	44.6	44.6	44.6
Numerator	0	10489	10489	10489	10489
Denominator	1	23518	23518	23518	23518
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	48.9	50	50	50	50

Notes - 2006
Based on Nebraska Open Mouth Survey of third grades 2004-2005 school year.

Notes - 2005
Based on Nebraska Open Mouth Survey of third grades 2004-2005 school year.

a. Last Year's Accomplishments
During this period of time, the Office of Oral Health was without a Director. The Office was staffed by a temporary employee assigned to the task of managing and responding to requests from local health departments, individual dental clinics and special school programs that address oral health. The Office averaged 24 requests for educational materials per month during this timeframe. In an addition, staff updated and expanded the materials list and oral health equipment such as tooth brushes that are made available to these interested parties. An ongoing effort to employee a full time dentist who can move the program from its current effort of basic education to have a real impact on dental access especially for children in low income environments.

During FFY 2007, Nebraska applied for and received technical assistance through HRSA and ASTDD for a State Access Workshop (SAW) for MCH oral health. Lifespan Health Services

began work with the federal contractor to determine how to best utilize this opportunity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. With technical assistance through MCHB/ASTDD State Access Workshop, began early stages of preparing strategic plan for children's oral health.				X
2. Provided educational materials on children's oral health to stakeholders and providers.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The federal contractor supporting SAW events traveled to Lincoln in February 2008, and conducted interviews and focus groups with oral health stakeholders. The contractor developed a briefing paper based on these discussions, which will guide the SAW event, scheduled for August 26, 2008. Also planned for August is a focus group with CYSHCN stakeholders to assess oral health needs for this population, as well as adults with disabilities.

c. Plan for the Coming Year

NOTE: Current state statute (71-193.01) requires that a licensed Dentist be appointed as Director of the Office of Oral Health and Dentistry within the Division of Public Health, Department of Health & Human Services. Attempts to attract a qualified Dentist to this position have not proven fruitful so these activities are based upon a plan to use a volunteer, part-time Dentist.

The Primary Goal of the Oral Health Program is to expand opportunities for low-income children to improve their oral health. Low-income will be defined by the CHIP eligibility standards under the Medicaid program, but not limited to CHIP participation. We propose to serve children from birth through 12 years of age. This effort shall have three components: 1)Use existing data sources to define the extent of oral health among children in our target population. Particular emphasis will be placed on the care provided/funded by the Medicaid program. Determine the impact of availability of care versus lack of request. 2)Build a program that responds to the informational and access issues defined in the needs analysis. This effort will be focused on building infrastructure within local health departments and, where appropriate, within the school nurse program. 3)Work with the local DHHS staff to ensure that all CHIPS eligible children are able to take full advantage of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) within the Medicaid program which encourages dental screening and treatment.

Strategies developed through the State Access Workshop (SAW) to be held in August 2008 will help inform these activities.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	4.4	4.4	4.4	3.8	3.4
Annual Indicator	6.6	3.3	5.3	3.8	3.8
Numerator	24	12	18	13	13
Denominator	364714	359029	338806	339983	341855
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	3.4	3.3	3.2	3.1	3

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death.

Notes - 2005
Provisional data due to birth certificate conversion in 2005. Denominator is 2004 census estimate and will be updated to 2005 when data is finalized. Targets are based on 2% yearly improvement.

a. Last Year's Accomplishments
The Safe Kids Nebraska program is responsible for child passenger safety activities and outreach for the State of Nebraska. In 2007, over 55 child safety seat check events were held and 22 fitting stations checked seats on a monthly basis. Through these events, over 7000 seats were checked, and over 2500 seats were distributed. The monetary support came from Safe Kids Worldwide/General Motors, Preventative Health and Human Services block grant and the Nebraska Department of Highway Safety, as well as many local sponsors.

Nebraska Child Passenger Safety Instructors from various agencies across the state conducted Child Passenger Safety certification classes in Scottsbluff, Omaha, Hastings, Grand Island, Auburn, Lincoln and North Platte. Through the PHHS Block Grant, staff was present as instructors and provided technical assistance prior to each course. Through these courses over 100 technicians were trained and certified. A child passenger safety technician update was held in Kearney in April 2007. Around 200 Child Passenger Safety technicians were in attendance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promoted child passenger safety through the Safe Kids program, including child safety seat check events.			X	
2. Conducted National Highway Traffic Safety Administration certification courses for safety seat checks.			X	
3. Provided classes on special needs child passenger safey through the Nebraska All Kids Ride Safe program.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Nebraska All Kids Ride Safe program is continuing to grow, providing points of contact and referral to families with special transportation needs. Partners for this program include: Children's Hospital (Omaha), Madonna Rehabiliation Hospital (Lincoln), Saint Francis Medical Center (Grand Island), Faith Regional Medical Center (Norfolk), Good Samaritan Hospital (Kearney) and Nebraska Department of Health and Human Services.

Another year of Child Passenger Safety trainings is in process. There have been three classes in 2008 so far, located in Kearney, Bellevue, and Scottsbluff. There is a class planned for Lincoln in September. The Nebraska Child Passenger Safety Advisory committee meets quarterly via conference call and in person as needed. They make decisions on Child Passenger Safety classes, statewide planning policies, and other guidelines for the program. Child Passenger Safety check-up events continue statewide with funding from Safe Kids Worldwide, Nebraska Office of Highway Safety and the PHHS block grant.

c. Plan for the Coming Year

Another year of child passenger safety technician certification classes will be scheduled. Funding will come from the Nebraska Office of Highway Safety. The Nebraska Child Passenger Safety Advisory committee will continue to meet to further discuss and implement the strategies for providing child passenger safety in Nebraska. A Child Passenger Safety technician update will take place in Kearney in March. Child Passenger Safety check-up events will be held regularly statewide to provide education and assistance to families on correct use and installation of child restraints. Funding for these events comes from the PHHS block grant and Safe Kids Worldwide.

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Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				35.8	48.8
Annual Indicator			35.1	47.9	55.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	56	57.3	58.5	59.6	60.8

Notes - 2007
Data source is CDC's National Immunization Survey, 2006 (weighted data).

Notes - 2006
Data source is CDC's NIS, 2005.
Verified with 2006 PRAMS indicated that 80% have attempted to breastfeed (ever) and 44.5 still breastfeeding at the time of survey.

Notes - 2005
Data is CDC's NIS, 2004. Variables are State=Nebraska and Breastfeeding duration in days>=180 days. Targets are set at 2% improvement per year.

a. Last Year's Accomplishments
Loving Support Breastfeeding Peer Counselor Program continued to operate in three WIC local agencies in Nebraska -- Central District Health Department, Family Service WIC, and Western Community Health Resources.
Breastfeeding training was provided for all WIC staff at a state wide training presented by Every Mother Inc at the WIC/CSFP Annual meeting.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Continued Loving Support Breastfeeding Peer Counseling program in selected WIC sites.	X		X	
2. Provided training to WIC staff on breastfeeding promotion and support topics.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Several WIC activities occurred in FFY 2008. Breastfeeding Peer Counselor programs continue in three WIC Local Agencies. Three new breastfeeding peer counselors were trained for the Family Service Program. Breastfeeding Peer Counselors will participate in a 1-day workshop to

increase their breastfeeding knowledge. Peer Counselor Supervisors will attend additional training. State WIC Breastfeeding Coordinator, one WIC Local Agency Breastfeeding coordinator, and the Breastfeeding Coordinator with Nebraska's Chapter of the AAP attended the United States Breastfeeding Committee's Conference on Coalitions in January 2008. The WIC Local agency at Lincoln/Lancaster County Health Department has a contract with MilkWorks, to provide the services of one lactation consultant for WIC breastfeeding mothers. State WIC Breastfeeding Coordinator serves as the contact/host for the Bi-monthly State Breastfeeding Coalitions Teleconferences, sponsored by CDC and the USBC.

With Title V/MCH Block Grant support, a contractor has been working with stakeholders to form a Nebraska Breastfeeding Support Coaltion. A planning event was held in May 2008, with a final report due this month.

c. Plan for the Coming Year

Current WIC programs in breastfeeding peer counseling will continue activities. The Nebraska Association of Local WIC Agencies will research opportunities to provide funding to expand the Breastfeeding Peer Counselor program to additional WIC agencies. In 2008 the Nebraska WIC Program revised the needs assessment and strategic planning process for selecting program goals. The five-year goal selected to be worked on by the State WIC agency and all Local WIC agencies is related to the rate of exclusively breastfed infants: By August 1, 2013 increase the percent of exclusively breastfed infants and 6 months of age. Strategy: Provide encouragement, education and support for mothers to exclusively breastfeed for the first six months.

The WIC Breastfeeding workgroup will continue work related to materials, standards and resources for breastfeeding promotion. Job appropriate breastfeeding training will be provided for WIC local agency staff.

The report generated from stakeholder discussions in May 2008 will guide future work on forming a Nebraska Breastfeeding Support Coaltion.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	95	95	99	99.7	99
Annual Indicator	97.6	98.2	99.6	98.9	99.0
Numerator	25275	25966	26179	26615	26669
Denominator	25900	26443	26293	26898	26948
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	99.9	100	100	100	100

a. Last Year's Accomplishments

Nebraska Revised Statute SS71-4742 established that newborn hearing screening would voluntarily become the standard of care and that 95% of newborns would be screened for hearing prior to hospital discharge. During calendar year 2007, 100% of the 63 birthing facilities were conducting newborn hearing screening and all but one were conducting the screenings during the birth admission. Hospitals reported screening the hearing of 99.0% of the newborns during birth admission. The average refer rate was 3.5%. Outpatient re-screenings and/or diagnostic evaluations were completed for 85.8% of those needing follow-up services. Follow-up services were initiated at an average of 30.0 days of age. There were 45 infants identified with a permanent childhood hearing loss, an incidence of 1.66 per thousand newborns. The average age of identification was 76.3 days, with 72.1% diagnosed prior to 3 months of age. Of the 45 infants identified with a permanent hearing loss, 68.9% were verified for special education services through Part C and 90.3% of those were verified prior to 6 months of age. Of the 31 infants verified for services, 80.6% were identified as having a medical home.

Program staff worked with providers to improve reporting and referrals for screening, diagnosis, and follow-up treatment. Collaborative linkages were maintained with family support programs, early childhood education, related professional associations, and research projects. Six Early Head Start programs continued to participate in the Hearing Head Start demonstration project with the National Center for Hearing Assessment and Management. The electronic data reporting system, an integrated module of the Vital Records system, was completed and all birthing facilities began reporting hearing screening results for all occurrent births on January 1, 2007. The NE-EHDI program completed participation in National Initiative for Child Healthcare Quality's Learning Collaborative to reduce the number of infants who are lost to follow-up. In partnership with the University of Nebraska-Lincoln and the Nebraska Association for the Education of Young Children, the Nebraska Children's Hearing Aid Loaner Bank was established. Family support and audiology advisory groups provided input into program direction and approaches. Support was provided to the new Hands and Voices chapter in Nebraska. A process for primary care providers to retrieve the dried blood spot for babies identified with a permanent hearing loss to determine etiology, especially congenital CMV, was implemented.

The activities were a mixture of infrastructure building (Centers for Disease Control and Prevention cooperative agreement for integration and linkage of electronic data system, revision of forms, educational materials and procedures) and population-based (screening and tracking). The target population is newborns and infants.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Administered Newborn Hearing Screening Program as per NE Rev Stat §71-4742, including reporting/tracking provisions			X	
2. Promoted periodic screening of older infants and toddlers through Hearing Head Start and Hear and Now projects			X	
3. Reviewed and revised screening, diagnostic, and referral protocols			X	
4. Continued development of electronic data reporting and tracking system as an integrated module of the Vital Statistics Reporting System				X
5. Through HRSA/MCHB Universal Newborn Hearing Screening and Intervention grant, supported implementation of medical home, family-to-family support systems, and professional development of related professionals				X
6. Through CDC EHDI cooperative agreement, planned				X

integration of electronic data reporting system with related child data systems				
7.				
8.				
9.				
10.				

b. Current Activities

Enhancement of the integrated electronic data reporting system to include input by additional professionals and to link/integrate with related early childhood data systems is continuing. Quality assurance reports have been developed, based on the data system, and will provided to birthing facilities quarterly. Continue technical assistance and training support to six Early Head Start grantees serving 651 newborns, infants and toddlers through the Hearing Head Start project. Provide training and technical assistance to primary health care practices that are beginning to conduct otoacoustic emissions (OAE) screening using the Hear and Now curriculum developed by National Center for Hearing Assessment and Management. Train birthing facility staff on National Initiative for Child Healthcare Quality's model for improvement to reduce the number of infants who are lost to follow-up. Provide newborn hearing screening training materials, developed by National Center for Hearing Assessment and Management, to all birthing facilities. In partnership with the University of Nebraska-Lincoln and Nebraska Association for the Education of Young Children, expand the Nebraska Children's Hearing Aid Loaner Bank for young children recently identified with a permanent hearing loss. Fully implement the single point of entry for parents of children recently identified with a hearing loss in partnership with the Early Development Network (Part C) and other partners.

c. Plan for the Coming Year

With the benchmark of 95% of newborns screened during birth admission having been consistently met, program activities for calendar year 2009 will continue to focus on implementing the ongoing mandates of Nebraska's Infant Hearing Act: expansion, enhancement and maintenance of the reporting and tracking system, collection of required data, application for federal funding, and providing consumer and professional education. The goals and objectives identified in the federal funding applications (HRSA/MCHB and CDC/NCBDDD/EHDI) will be implemented to further develop the screening, diagnostic and services systems; expand the reporting and tracking system, integrate with other child data systems; and refine the quality assurance mechanisms.

Continue efforts from FFY 2008 for which space was not sufficient to record under Current Activities:

In partnership with audiologists, primary care providers, and Part C services coordinators, disseminate the completely revised Parent Resource Guide/Healthcare Notebook to families with children recently identified with a permanent hearing loss.

Support the professional development of audiologists and early intervention providers through workshops at statewide conferences and through national web-based educational programs.

Continue to expand the scope of advisory committee input into program development.

Establish protocols to facilitate the retrieval of the newborn dried blood spots for babies identified with a permanent hearing loss to screen for congenital cytomegalovirus and genetic causes of hearing loss.

Develop a website for the Early Hearing Detection and Intervention Program.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	6	5.5	12.2	11.3	12.3
Annual Indicator	11.6	12.4	11.5	12.6	13.9
Numerator	17000	18000	18000	19000	22000
Denominator	146000	145000	156000	151000	158000
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13.6	13.3	13.1	12.8	12.5

Notes - 2005
2005 data is uninsured children 0-18 year old<200%FPL . Census Bureau.

Targets =2% yearly improvement.

a. Last Year's Accomplishments
The Department of Health and Human Services Division of Medicaid and Long-Term Care contracted with Mercer Health Government Human Services Consulting services provided by Mercer Health & Benefits LLC, to assist in developing a series of reports related to Title XXI. Similar to other states, program expenditures for Medicaid (Title XIX) and the State Children's Health Insurance Plan (Title XXI) in Nebraska continue to increase. In an effort to ensure long-term savings and program stability for the Title XXI program, the legislature recognized the necessity for studying and developing recommendations relating to the provision of health care and related services for Medicaid-eligible children under the state children's health insurance program as allowed under Title XIX and Title XXI of the federal Social Security Act. The study and recommendations included, but were not limited to the organization and administration of the program; the establishment of premiums, copayments and deductibles; and the establishment of limits on the amount , scope and duration of services offered to recipients. An initial report was presented to the Medicaid Reform Council and the Health and Human Services Committee of the Legislature on October 1, 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MHCP continued to provide/pay for limited specialty services for CSHCN within available resources	X			
2. Gap filling services provided through 6 FQHCs and 5 Indian Health Services facilities.	X			
3. Policy makers received and reviewed report of options under Title XXI, Title XIX, and the DRA, guiding possible legislative and				X

administrative actions related to insurance coverage for children.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The final written report prepared under contract with Mercer, presented to the Governor, Medicaid Reform Council and Health and Human Services Committee of Legislature on December 1, 2007, recommended that the state convert its current Medicaid expansion State Children's Health Insurance Program (CHIP) into a separate stand-alone State Children's Health Insurance Program (SCHIP). This option provides the maximum flexibility to the State for administering its Title XXI program. Four scenarios for cost sharing and administration of the SCHIP were outlined in the final report. The final report is available at http://www.dhhs.ne.gov/med/reform/

c. Plan for the Coming Year
Action on the aforementioned report is pending.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				32	31.4
Annual Indicator			32.9	33.5	34.4
Numerator			4848	5036	5263
Denominator			14724	15028	15311
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	33.7	33	32.4	31.7	31

Notes - 2005
Targets are set at 1% yearly improvement and are determined by Nebraska WIC.

a. Last Year's Accomplishments
WIC specific activities: The SNAP (State Nutrition Action Plan) fruit and vegetable promotion campaign began in June 2007. Campaign materials were developed by members of the Community Nutrition Partnership Council, and combined messages from the Pick a Better Snack and Fruits and Veggies More Matters. Packets of materials for three color groups, including posters, coloring sheets, fact sheets, recipes and stickers were distributed to all WIC local agencies.

Lifespan Health Services Unit activities: A workgroup was formed to conduct problem analyses and develop strategies to address the priority need of healthy weight among women of childbearing age and children. During FFY 2007, preliminary data analysis and literature reviews were conducted, and the work group began its deliberations. Workgroup members included stakeholders from the WIC Program, as well as Title V/MCH supported projects and other interested organizations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Planned and implemented an educational initiative for WIC families focused on fruit and vegetable consumption.			X	
2. Participated in the Community Nutrition Partnership Council to collaborate and coordinate USDA State Nutrition Action Plan (SNAP) activities.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Pick a Better Snack and Fruits and Veggies More Matters -- SNAP materials for 2 color groups were distributed to WIC local agencies in FY2008. Nebraska WIC program participated in the Community Nutrition Partnership Council to collaborate on SNAP promotion activities. Training on the Satter Feeding Dynamics Model was provided for 120 WIC professional staff as part of the Partners in Lifespan Health conference.

The Healthy Weight Workgroup completed its strategy development activities in FFY 2008. Three logic models were developed around 3 problem statements and associated theories of change. These Logic Models were incorporated into the Request for Applications for MCH community based projects issued in May 2008. Applications were received the week of July 1, 2008. Awards will be made for a 3 year period beginning October 1, 2008.

c. Plan for the Coming Year

The Nebraska WIC Program will continue to participate in the state level Community Nutrition Partnership Council to collaborate and coordinate USDA SNAP fruit and vegetable promotion activities. WIC Nutrition coordinator will attend the Food and Nutrition Service' Third National Nutrition Education Conference scheduled for August 3-5, 2009 in Arlington, Virginia. In 2008 the Nebraska WIC Program revised the needs assessment and strategic planning process for selecting program goals. The five-year goal selected to be worked on by the State WIC agency and all Local WIC agencies is related to decreasing the rate of childhood overweight and obesity: By August 1, 2013 reduce the percentage of Nebraska WIC children ages 2-4 that are at or above the 85th percentile BMI-for-age. Strategies: Use a family feeding dynamics approach to provide nutrition education & encourage family lifestyle behaviors that increase physical activity. Action steps will consist of evidence-based interventions for prevention of childhood overweight.

Beginning October 1, 2008, community-based MCH projects will begin, with some (to be determined) addressing health weight among the MCH population, including children 2-5 and who

may also be WIC participants.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				11.9	11.7
Annual Indicator			12.2	11.8	11.5
Numerator			3186	3148	2986
Denominator			26143	26629	25884
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	11.3	11	10.8	10.6	10.4

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

Notes - 2005
Provisional data due to birth certificate conversion in 2005. Targets are based on 2% yearly improvement.

a. Last Year's Accomplishments
Tobacco Free Nebraska Program (TFN) provided financial resources for several tobacco cessation activities in MCH this year. TFN purchased copies of the workbook "Need Help Putting Out That Cigarette" produced by ACOG and Smoke Free Families in English and Spanish. These workbooks were distributed to agencies which provide tobacco cessation classes for pregnant women to facilitate their class work. Another activity is the production of a 30 second television ad titled "Quit Now" that aired in FFY 2008 on Nebraska networks. This ad targets pregnant women and new mothers on the harmful effects second hand smoke has on your children, and complements the tobacco cessation resource materials available through the Perinatal, Child and Adolescent Health (PCAH).

TFN also collaborated with the DHHS School and Child Health Program and the Nebraska School Nurses' Association to build the capacity of Nebraska's professional school nurses to deliver tobacco prevention activities for children, youth, and families at the local level. Twenty-one school districts applied and received awards up to $1,500 to purchase materials and supplies to address prevention goals in the areas of second-hand smoke, spit tobacco, media literacy, general prevention, and/or smoking and asthma. District school nurses developed and delivered the prevention activities during the 2007-08 school year, and will report on the effectiveness of the tobacco prevention intervention; and assessment of progress toward the goal of building capacity of school nurses to participate in prevention activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained, promoted, and distributed perinatal tobacco cessation materials to health care providers and community organizations.			X	
2. School nurses implemented tobacco cessation activities within NE schools.			X	
3. Continued collaborations with Tobacco Free Nebraska, including production of a 30 second PSA and distribution of materials to tobacco cessation programs serving pregnant women.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Lifespan Health Services staff and TFN staff developed a promotional plan of new activities to increase tobacco cessation of pregnant women. Educational materials have been updated and a new order form developed. A letter encouraging health care providers to discuss the importance of tobacco cessation for pregnant women, and a description of resource materials available will be sent in the near future. The "Quit Now" television ad aired the week of Mother's Day week about the danger of tobacco and secondhand smoke for women.

The Nebraska legislature appropriated $500,000 state general funds to cover the costs of tobacco use cessation counseling and tobacco use cessation pharmaceuticals for adult Medicaid eligibles. It is estimated that 3% of the adult Medicaid population would seek smoking cessation assistance each year, and this includes pregnant women. This service is slated to begin December 1, 2008, however, the amended Medicaid state plan must be approved and rules/regulations must promulgated before starting services

School districts who received TFN/School and Child Health Program awards developed and delivered prevention activities during the 2007-08 school year. Recently, these school nurses from these districts reported on their projects at the "24th Annual School Health Conference.

c. Plan for the Coming Year

Nebraska Title V and TFN will continue long-standing collaborations to promote tobacco prevention and cessation within the MCH populations. New initiatives will be developed as resources permit.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	8.5	8	7.5	13.4	13.1

Annual Indicator	9.9	11.6	13.7	16.1	12.3
Numerator	13	15	18	21	16
Denominator	130871	129578	131107	130338	130506
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	12.8	12.6	12.3	12.1	11.8

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death.

I have switched to a three year rolling average based on reviewer recommendation.

Notes - 2005
Provisional data due to birth certificate conversion in 2005. Denominator is 2004 census estimate and will be updated to 2005 when data is finalized. Targets are based on 2% yearly improvement.

a. Last Year's Accomplishments
The Suicide Prevention Workgroup followed up on recommendations made at the Suicide Prevention Symposium held in June 2006. The work grup focussed on the following recommendation: "Explore collaboration between the Nebraska Department of Education, the Nebraska Health and Human Services System, and the State Suicide Workgroup to develop a statewide program of suicide assessment and prevention to integrate in school curricula." With funding from the KIM foundation, Teen Screen was chosen as a tool to use for assessmen and plans were made to pilot in several communities. The Workgroup was awarded funding by the Community Health Endowment to implement the LOSS (Local Outreach to Suicide Survivors) program, another one of the recommendations included in the 2006 Symposium report. This program brings immediate support to survivors as close to the time of death as possible.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. With support of Kim Foundation, initiated piloting of Teen Screen in selected school districts.			X	
2. Implemented LOSS, support for survivors project, with resources provided through the Community Health Endowment.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Suicide Prevention Coalition has conducted two training sessions toward the implementation of the LOSS (Local Outreach to Suicide Survivors) program. This program brings immediate

support to survivors as close to the time of death as possible. Currently work is being done with local law enforcement to plan for implementation. Several schools who are interested in implementing Teen Screen have been identified. A barrier has been permission from local school boards. The Suicide Coalition is continuing to work with these communities. The SOS (Signs of Suicide) Program, a school-based suicide prevention program, is being implemented in the Lincoln Public School System. Training was conducted in June, 2008. Don Belau, Ph.D., co-chair of the Suicide Coalition, conducted a community presentation "Recognizing & Responding to Threats of Adolescent Self-Harm" at Bryan LGH on June 11. The program was very well attended and well-received.

c. Plan for the Coming Year
Efforts will continue toward implementation of the LOSS program and the Teen Screen Program. The Suicide Coalition has worked with the University of Nebraska Public Policy Center to apply for SAHMSA funding for youth suicide prevention. This funding would provide for implementation of Teen Screen in rural, urban and tribal settings. If Nebraska does not receive this funding, other funding will be sought.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	90	90	74.3	78.2	73.7
Annual Indicator	65.4	75.2	74.6	71.9	68.1
Numerator	206	279	217	218	220
Denominator	315	371	291	303	323
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	69.2	70.6	72	73.5	74.9

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

Notes - 2006
Targets have been reset

a. Last Year's Accomplishments
All UNMC/UNO Master of Public Health Program students must complete a service learning capstone project. A current student completed her capstone project that focused on Nebraska's perinatal system. The project produced a description of the current status of regionalized perinatal services in Nebraska. Specifically, there were two parts to the project. The first was a literature review of the historical and current status of perinatal regionalization nationally.

Essential background for this part was the national Guidelines for Perinatal Care, Fifth Addition, American Academy of Pediatrics and The American College of Obsetricians and Gynecologists, for definitions of and guidelines for levels of care, supplemented with current research and position papers on perinatal regionalization.

Second was an in depth examination of the current Nebraska system. With the guidance of Lifespan Health Services staff and others, the student gathered information from applicable DHHS programs such as Medicaid, from Nebraska hospitals, and from Nebraska health care provider organizations. This capstone project provided a detailed description of the current status of perinatal regionalization in Nebraska.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Completed analysis of data related to location of delivery, transport of mothers and infants, and infant outcomes, for future policy development related to transport and/or regionalization.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A second College of Public Health student will continue work on levels of care as her Capstone project in 2008. Using data gathered in 2007, the second student will 1) Examine the distribution of births in Nebraska over a 5-10 year time period according to hospital level of care criteria (3 groups categorized by level of maternity and neonatal care services); 2) Examine the distribution of low birth weight and very low birth weight births in Nebraska over a 5-10 year time period according to hospital level of care criteria; and 3) Examine the distribution of low birth weight babies born in level I and II hospitals that are transferred for care according to the birth certificate data. The public health questions to be explored include: should hospital administration recommend referring mothers with infants at risk for low birth weight to level II and III hospitals for delivery and neonatal care? Who should be referred and when? The student recently acquired IRB approval for the project and is beginning work in the near future. The culmination of both projects will be information to better develop recommendations and strategies related to levels of care and birth outcomes.

c. Plan for the Coming Year

The second graduate student will complete her project. Lifespan Health Services will utilize the project's findings for planning and to initiate conversations with birthing hospitals on maternal transport and related issues.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	90	90	84.6	79.3	80.9
Annual Indicator	83.3	82.7	77.8	71.5	73.4
Numerator	21574	21773	20332	19096	19003
Denominator	25900	26323	26144	26723	25897
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	74.8	76.4	77.9	79.5	81

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births). Over 2% of the data for this PM is missing/unknown.

Notes - 2006
Over 5% of the data for this PM is missing/unknown.

Notes - 2005
Provisional data due to birth certificate conversion in 2005. Targets are based on 2% yearly improvement.

NCHS confirms that conversion has consistently shown drop in access to 1st trimester care. The change is due to source of data. The new source is however, thought to be more accurate.

Therefore, 2005 will not be comparable to 1999-2004.

a. Last Year's Accomplishments
Lifespan Health Services continued to work with Nebraska Medicaid and its managed care contractor in reviewing prenatal care quality assurance data.

Title V/MCH community-based projects included one that provides prenatal care to at-risk women, and the Tribal set-aside programs provided direct and enabling services for pregnant women.

Emphasis on pre- and interconception care for women continued, including the Now and Beyond project in Omaha, supported through Title V/MCH Block Grant funding. These preconception efforts will have an impact on early entry into prenatal care over time.

Efforts started in 2006 continued, to promote Nebraska's Title V toll-free number, "Healthy Mothers, Healthy Babies" helpline. New marketing strategies were developed and incorporated into the Perinatal Depression project strategies as an additional means to promote use of the line.

A portion of TANF funds were earmarked in 2005 to fund a pilot project to provide referral and supportive services to women who are pregnant or believe they might be pregnant. These funds were administered by the Lifespan Health Services. During 2007, the grantee for this pilot project implemented outreach strategies for the project titled "Positive Alternatives" and made referrals to its network of subcontractors, including referrals to prenatal care providers and other services for

women and their families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued partnership with Medicaid Managed Care Program in monitoring quality of prenatal/perinatal care.				X
2. Provided Title V financial support to prenatal and preconception care provided through community based programs.	X	X	X	
3. Continued promotion of Healthy Mothers, Healthy Babies helpline			X	
4. Administered TANF funded program for supportive services for pregnant women or women who believe they are pregnant		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH/CSHCN Strategic Planning Workgroup that addressed preterm births and very low birth weight outlined strategies that focused on pre and interconception health care. Thus the emphasis on reaching women even before pregnancy continues. These strategies were incorporated into the RFA for community-based MCH projects issued in May 2008. In addition, Lifespan Health Services submitted an application for the First Time Motherhood/New Parents Initiative grant. The application focused on messaging to women 15-24 who are uninsured or at risk of being uninsured.

c. Plan for the Coming Year

With no expansions of Medicaid planned, or other initiatives focused on access to care, Lifespan Health Services will continue to develop pre and interconception health strategies. Women who are well informed, have reproductive life plans, and are engaged in taking care of their own health will be more likely to recognize the importance of prenatal care when they do become pregnant, and to seek out those services. They will also be more likely to have better health status as they enter pregnancy, compensating somewhat for a later entry into care should they have difficulty accessing care in the first trimester.

D. State Performance Measures

State Performance Measure 1: *Percent women (18-44) with healthy weight (BMI)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007

Annual Performance Objective				52.6	53.6
Annual Indicator			51.6	49.9	54
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	54.2	55.8	57	58.1	59.8

Notes - 2007
2007 NE BRFSS, weighted data.

Notes - 2006
2006 NE BRFSS, weighted data.

Notes - 2005
2005 NE BRFSS, weighted data.

a. Last Year's Accomplishments
The Nebraska/Douglas County ALC team attended the first on-sight meeting of the ALC held in December 2006. The team consisted of local representatives of chronic disease, WIC, and a community based preconception health program, an assistant professor of the School of Health Physical Education and Recreation, University of NE, as well as state MCH and chronic disease professionals. The Nebraska team developed vision, goals and opportunities for action. The team's main strategy is to expand an existing preconception program and integrate with a pre-existing social support group for women that focuses on behavior change. Focus groups were initiated in August, 2007. The second on-sight meeting of the ALC occurred in June, 2007 in which the teams focused on message development and evaluation.

The Office of Women's Health launched a project funded under the "Innovative Approaches to Promoting a Healthy Weight in Women" initiative. This three year project focuses on community-based interventions in both a rural and an urban settings. As part of MCH/CSHCN Strategic Planning, the Lifespan Health Services formed a Healthy Weight work group. This workgroup conducted a problem analysis specific to overweight among women of childbearing age and for prevention of overweight for mother/infant dyads. Strategy identification and the development of logic models continued into FFY 2008.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participated in the AMCHP/CityMatCh Healthy Weight Action Learning Collaborative, and used experience in planning NE interventions.				X
2. Implemented activities under "Innovative Approaches to Promoting a Healthy Weight in Women" grant.	X		X	
3. Healthy Weight work group (MCH/CSHCN Strategic Planning) completed logic model and action plan.				X
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
The Nebraska/Douglas County ALC team analyzed and incorporated the focus group findings to re-tool the social support group while working with the preconception programs/agencies to refer women to the group. A pilot support group was launched. The ALC met for the third time in December, 2007 to focus on evaluation and reporting. Depending on outcomes and funding the Nebraska team will replicate and grow the new support group in Douglas County and perhaps other communities in Nebraska.

The "Innovative Approaches to Promoting a Healthy Weight in Women" project has been fully implemented. Evaluation data is starting to come in regarding impact on health status and behaviors of women participating in the two sites.

The Health Promotion Unit received a grant award from the CDC for Nutrition, Physical Activity, and Obesity Prevention. This 5-year, $726,953 per year grant will substantively build Nebraska's capacity to develop and support comprehensive nutrition and physical activity efforts, including those for the women of reproductive age. The State Plan details the development and enhancement of supports within communities, schools and child care facilities, worksites and health care systems to improve environments, policies, and social supports for healthy eating and physical activity.

The MCH/CSHCN Strategic Planning Workgroup developed logic models focused on women of reproductive age. These logic models were incorporated into the RFA for community-based MCH projects.

c. Plan for the Coming Year
The applications received in response to the RFA for community-based MCH projects will be reviewed, scored, and awards made. One or more may address healthy weight for women. Lifespan Health Services will collaborate with the Health Promotion Unit in implementing the Nutrition, Physical Activity, and Obesity Prevention grant project. The Innovative Approaches to Healthy Weight in Women Project will continue. Lifespan Health Services will further develop life course approaches to pre and interconception health, incorporating healthy weight into strategies as resources permit.

State Performance Measure 2: *Percent of women of child-bearing age who report smoking in the last 30 days*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	22	19	19.3	17.5	21.4
Annual Indicator	25.2	21.1	25.4	21.9	19.5
Numerator	79968	68369			
Denominator	317204	324598			
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	19.1	18.7	17.4	17.9	17.6

Notes - 2007
20067 NE BRFSS, weighted data.

Notes - 2006

2006 NE BRFSS, weighted data.
Targets have been reset to 2% imprvement rather than HP2010.

Notes - 2005
2005 NE BRFSS, weighted data.

a. Last Year's Accomplishments
See National Performance Measure #15 for past accomplishments.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained, promoted, and distributed perinatal tobacco cessation materials to health care providers and community organizations.			X	
2. Continued collaborations with Tobacco Free Nebraska, including completion of school nurse tobacco prevention education project.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
See National Performance Measure #15 for current activities.

c. Plan for the Coming Year
See National Performance Measure #15 for future planned activities.

State Performance Measure 3: *Percent of women age (18-44) who report mental health not good 10+ days of past 30*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				10.1	13.2
Annual Indicator			10.3	13.5	13.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	12.9	12.7	12.4	12.2	11.6

Notes - 2007
2007 NE BRFSS, weighted data.

Notes - 2006
2005 NE BRFSS, weighted data.

Notes - 2005
2005 NE BRFSS, weighted data.

a. Last Year's Accomplishments
The work products of the Perinatal Depression Project were completed and rolled out during 2007. Resources for women and their families include: brochures in English and Spanish; posters in English and Spanish; web site www.dhhs.ne.gov/MomsReachOut; and a traveling exhibit. Provider resources include: web site www.dhhs.ne.gov/Perinatal Depression; interactive curriculum for continuing education for mental health practitioners, nurses and physicians; toolkit; a traveling exhibit; and brochures and posters.

In addition, three community-based programs received subgrants through a competitive RFP. (Central NE Early Childhood Mental Health System of Care Project in Hastings, Omaha Healthy Start, and Happy Moms, Healthy Kids - Child Saving Institute/Visiting Nurse Association in Omaha.

A press conference was held in June 2007, officially announcing these resources. It was well attended by the media, with news coverage on several television stations, radio, and in wide-circulation newspapers. The Lincoln Journal Star made the project a front page feature.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintained resources developed through Perinatal Depression project, including web sites, provider curriculum, and public information materials.			X	
2. Three community-based subgrants completed perinatal depression projects and used experience to sustain outreach, screening, and referral.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Lifespan Health Services continues to maintain and promote the Perinatal Depression Project web resources and printed materials continue to be distributed. Staff completed literature review new references will be added to the provider web site and the interactive curriculum will be updated. Staff are in the process of developing a comprehensive statewide referral list of Licensed Mental Health Providers/Psychologists/Psychiatrists for Nebraska providers.

c. Plan for the Coming Year
The Perinatal Depression Project web resources and printed materials will be sustained and promoted. Lifespan Health Services will also study women's mental health issues and needs not related to pregnancy and the postpartum period, in developing lifelong and intergeneratational strategies to improve health.

State Performance Measure 4: *Percent of teens who report use of alcohol in last 30 days*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	52	58	45.6	42	41.2
Annual Indicator	46.5	46.5	42.9	42.9	41.1
Numerator	60855	60855			
Denominator	130871	130871			
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	40.1	39.6	38.8	38	36.2

Notes - 2007
2007 YRBS did not achieve an adequate response rate.

Notes - 2006
2005 YRBS is a weighted survey. YRBS is conducted bi-annually.

Notes - 2005
2005 YRBS is a weighted survey.

a. Last Year's Accomplishments
Within Lifespan Health Services, Youth Development principles and practices were promoted as the foundation for underage drinking prevention efforts. A community forum to this effect was conducted in Norfolk and a community summer youth activity was supported in Hastings through Nebraska Partnerships for Positive Youth Development (NPPYD). A web based survey conducted by NPPYD identified organizations and communities targeting prevention of underage alcohol use. Abstinence from alcohol and drugs was promoted within nine sub grant communities under Nebraska's abstinence grant.

In October of 2006 the Nebraska Department of Health and Human Services (NDHHS) received a Strategic Prevention Framework State Incentive Grant (SPF SIG) from the Center for Substance Abuse Prevention in the Substance Abuse and Mental Health Services Administration (SAMHSA). Administered within the Community Development and Preparedness Unit, this grant project has three overarching goals, which include:
• Prevent the onset and reduce the progression of substance abuse, including underage drinking;
• Reduce substance abuse related problems in communities; and
• Build prevention capacities and infrastructure at the state/tribal and community levels.
One of the major requirements of the SPF SIG is to develop a state substance abuse prevention plan using the Strategic Prevention Framework (SPF) model. SPF is an outcomes-based prevention model that focuses on the substance abuse consequences and consumption patterns that need to be changed. The SPF model also uses a public health approach that focuses on achieving positive health outcomes for the entire population, rather than a sub-set of individuals. The work carried out through SPF SIG into FFY 2008 has provided additional focus to the issue of underage drinking.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued to develop and promote NE Parnerships for Positive Youth Development.			X	X
2. Strategic Prevention Framework State Incentive Grant completed assessment and began identification of priorities for local substance prevention projects				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Adolescent Health Program within Lifespan Health Services has continued participation on the task force resolving issues and barriers to implementing the YRBS, YTS and NRPFSS surveys to be conducted 2009. Data from these surveys specifically NRPFSS support and enhance the promotion of youth development principles and practices as the infrastructure for all prevention programming. Lessons learned on promoting science-based approaches to teen pregnancy prevention will be applied to underage drinking prevention efforts. As part of the Abstinence Education Grant, parents and educators were informed of the role underage drinking plays in early sexual activity among teens.

The Adolescent Health Program will collaborate with the Strategic Prevention Framework, State Incentive Grant (SPF SIG) project and coordinate underage drinking prevention efforts with this project. SPF SIG released an epidemiologic profile in December 2007 and issued a strategic plan in March 2008. Nebraska's SPF SIG will focus exclusively on three alcohol-related priorities. The three priorities that were chosen were:

- Prevent alcohol use among persons 17 and younger;
- Reduce binge drinking among 18-25 year olds;
- Reduce alcohol impaired driving across all age groups.

A Request for Applications for Strategic Prevention Framework State Incentive Grant (SPF SIG) projects to be funded at the community level was issued April 29, 2008, and applications wee due on June 18, 2008.

c. Plan for the Coming Year

The Adolescent Health Program plans to begin development of a blueprint for action for identified adolescent health issues. Reducing underage drinking will be among those areas to be addressed as well as teen mental health and access to care. Youth Development practices and principles will be the framework for strategic planning in the areas identified. Lifespan Health Services will collaborate with SPF SIG activities.

State Performance Measure 5: *Percent premature births (births<37 weeks)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				8.7	9.8
Annual Indicator			9.8	10.0	9.6
Numerator			2566	2676	2475
Denominator			26144	26723	25897
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	9.6	9.4	9.2	9	8.8

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

Notes - 2005
Provisional data due to birth certificate conversion in 2005.

a. Last Year's Accomplishments
This state performance measure was newly established upon completion of the five-year comprehensive needs assessment in 2005. Though many Title V and related MCH activities have reduction in preterm births as a desired outcome, Nebraska did not have specific, focused strategies at the state-wide level. Local efforts, such as Omaha Baby Blossoms, Omaha Healthy Start, Northern Plains Healthy Start, and others have been working towards reductions in infant mortality and contributing factors including preterm births.

Late in 2006, the Office of Family Health launched a MCH/CSHCN Strategic Planning process, and chose preterm/low birth weight as one of three priority needs to initially address. During FFY 2007, a work group began reviewing the literature and conducting a problem analysis.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborated with community based initiatives including Northern Plains Healthy Start, Omaha Healthy Start, and Omaha Baby Blossoms.				X
2. Continued partnership with Medicaid Managed Care Program to design/monitor/enhance quality assurance activities for prenatal care, with preterm births as an outcome measure.				X
3. Preterm/LBW work group (MCH/CSHCN Strategic Planning) completed logic model and action plan.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Preterm/Low Birth Weight Work Group completed its review of the literature and data, then reviewed evidence based interventions for the prevention of preterm/low birthweight. Three logic models were developed, each addressing a range of life course approaches including pre and interconception health. These logic models were incorporated into the RFA for community-based

MCH projects, issued May 2008. Applications were received the week of July 1, 2008, and are currently being reviewed. Awards will be made for a 3-year period that begins October 1, 2008.

c. Plan for the Coming Year
The prevention of preterm births and low birth weight will be one of 3 priority goals for community-based MCH projects for the next 3 years. Lifespan Health Services will continue to explore strategies and opportunities for resources to support state level prevention efforts, particularly life course and pre and interconception strategies.

State Performance Measure 6: *Rate of infant death to adolescents (age 15-17)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				7.7	7.5
Annual Indicator	7.6	14.9	8.7	8.1	
Numerator	5	10	6	5	
Denominator	656	670	690	616	
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	7.4	7.3	7.1	6.9	6.7

Notes - 2007
Data not yet available.

Notes - 2006
Data not yet available.

Notes - 2005
Provisional data due to birth certificate conversion in 2005.

a. Last Year's Accomplishments
This state performance measure was also new in 2006, following the comprehensive needs assessment completed in 2005. A wide range of activities addressed reducing risks for adolescent pregnancy (Abstinence Education, Title X Family Planning, etc.) and several prenatal care projects focused on improving outcomes for high-risk pregnant women including adolescents (Omaha and Northern Plains Healthy Start, the Title V funded Maternal Care Project, and others).

A state team comprised of members from Lifespan Health, Douglas County Health Department and Region V Behavioral Health attended a roundtable training event sponsored by AMCHP/CityMatCH specific to science-based approaches to teen pregnancy prevention.

The Preterm Birth/Low Birth weight work group evaluated national literature and Nebraska-specific data related to birth outcomes for adolescent mothers. See SPM#5 for more information on these planning activities.

Included in the appropriations bill passed by the Legislature in 2007 are funds for the Medicaid Program for the purposes of nurse visitation for Medicaid-eligible pregnant teens. Initial discussions were held between Lifespan Health Services and Medicaid regarding this development and coordination with other home visiting efforts funded by Title V/MCH Block Grant and by state general funds also recently appropriated to Protection and Safety.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reduced risks for adolescent pregnancy through reproductive health services, abstinence education, and postive youth development.	X	X	X	
2. Provided prenatal care and enabling services for high-risk pregnant women including adolescents through Title V funded Maternal Care project.	X	X		
3. Administered TANF-funded pregnancy support project.		X		
4. Collaborated with Protection and Safety and Medicaid on home visitation programs.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The collaborative work among Protection and Safety, Title V/MCH, and Medicaid in regards to home visitation for at-risk families, including pregnant teens, continuef. Expectations for evidence-based home visitation models were developed and incorporated into a Request for Bids for home visitation, both for Medicaid eligible pregnant and parenting teens, and for families at-risk for child abuse and neglect. Contracts were awarded this spring.

The Preterm Birth/Low Birthweight Work Group logic models, as incorporated into the RFA for community-based MCH projects, will have the potential for guiding communities towards life course and pre- and interconception stragegies impacting adolescents and their health behaviors and outcomes.

c. Plan for the Coming Year

Through community-based projects selected through the competitive process, pre and interconception health through life course approaches will be promoted. The goal is to reduce rates of preterm and low birth weight births, including those associated with teen pregnancy.

State Performance Measure 7: *Incidence of confirmed SIDS cases (per 1,000 live births) among African American and Native American infants*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	2.5	2.2	2.5	2.7	2.6
Annual Indicator	2.8	2.8	3.0	2.7	2.3
Numerator	25	26	29	27	23
Denominator	9073	9325	9579	9960	9901
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	2.3	2.3	2.3	2.3	2.3

Notes - 2007

2007 Death file is incomplete, missing out of state deaths and few thousand causes of death. Because numbers are so small this is (and has been) a 5 year average.

Notes - 2006
Because numbers are so small this is (and has been) a 5 year average

Notes - 2005
Because numbers are so small this is (and has been) a 5 year average

a. Last Year's Accomplishments
Through the efforts of Baby Blossoms, an Omaha area collaborative, a vigorous safe sleep campaign has been in place in Douglas County. The Douglas County Health Department facilitated the efforts that included development of curricula for health care and child care providers, educational materials, and public awareness events.

The 2006 legislative session yielded a new law with several provisions related to SIDS, sudden infant death, and shaken baby syndrome. LB 994 included provisions requiring: training on SIDS, Shaken Baby Syndrome, and child abuse for licensed child care providers; inclusion of SIDS and Shaken Baby Syndrome information in Learning Begins at Birth, a booklet provided to all new parents through a collaboration of the Nebraska Department of Education and HHSS; hospital-provided information to parents of newborns via video and written materials on sudden infant death, shaken baby syndrome, dangers of bed sharing, and other related risks; and a public awareness campaign regarding SIDS and Shaken Baby Syndrome. The Child Care Licensing unit took the lead on the child care training provision, and the Lifespan Health Services, along with Protection and Safety, took the lead on the other provisions. During FFY 2007, materials were developed and disributed to hospitals.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Completed implementation of SIDS and safe sleep provisions of LB 994, including hospital based education and public awareness campaign.			X	
2. Douglas County Health Department continued to promote its "Nothin' But Baby" campaign.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
During FFY 2008, a surge in the number of sleep-associated deaths in which the infant was sharing a bed with another person resulted in intensified educational efforts on the risks of bed-sharing. A letter was mailed by DHHS to health care providers, urging them to counsel families accordingly. Baby Blossoms in Omaha launched a campaign specific to bed-sharing as a risk for

sudden unexpected infant deaths.

The provisions of LB 994 were fully implemented, with the exception of Spanish language videos. Those videos are currently in production.

Reducing rates of infant mortality and eliminating disparties for SIDS and other sudden unexpected infant deaths was included as a goal for the competitive RFA for community-based MCH projects, issued May 2008. Applicants could choose two associated outcomes related to this performance measure: health and human service providers deliver consistent, accurate messages on safe sleep practices for infants; and parents and other caregivers routinely provide safe sleeping environments for infants.

c. Plan for the Coming Year
The Department will continue to collaorate with Baby Blossoms on promoting safe sleep messages, and will maintain support of hospitals and child care providers in meeting the requirements of LB 994. One or more community-based projects may be funded that address SIDS/SUID.

State Performance Measure 8: *The percent of African American women beginning prenatal care during the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	90	90	79.5	69.9	71.3
Annual Indicator	72.1	72.2	68.6	58.8	58.4
Numerator	1044	1114	1033	1030	1054
Denominator	1447	1543	1505	1752	1804
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	60.4	61.6	62.8	64	65.4

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births). Nearly 7% of the data for this PM is missing/unknown.

Notes - 2006
Nearly 10% of the data for this PM is missing/unknown.

Notes - 2005
Provisional data due to birth certificate conversion in 2005.

NCHS confirms that conversion has consistently shown a drop in access to 1st trimester care. The change is due to source of data. The new source is however, thought to be more accurate.

Therefore, 2005 will not be comparable to 1999-2004.

a. Last Year's Accomplishments
Baby Blossoms and Omaha Healthy Start continued to provide leadership in improving prenatal and preconception care for women, with particular attention to disparities in outcomes experienced by African American women. Title V funds continued to support the Maternal Care project. The Lifespan Health Services and the Child Death Review Team Coordinator continued to work with Baby Blossoms and the Douglas County Health Department in conducting a FIMR project, which continues to yield information on access issues for at-risk women.

The Medicaid Managed Care Program utilized performance measures developed in conjunction with Lifespan Health Services as par of a quality improvement initiative to improve prenatal care for the Medicaid Managed Care population. This initiative has been tracking entry into prenatal care as one of the indicators. Efforts continued to better promote the Healthy Mothers, Healthy Babies help line, incorporating outreach and public awareness messages related to prenatal care.

A TANF funded project administered by the Office of Family Health continued as a pilot. The project funded in the Omaha area provides services to women who are pregnant or believe they may be pregnant, including referrals to prenatal care.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborated with local projects including Omaha Baby Blossoms and Omaha Healthy Start.				X
2. Promoted and supported data analysis to better understand access issues, such as Omaha's FIMR project and Medicaid Managed Care prenatal care data.				X
3. Administered TANF funded project for pregnant women or women who believe they are pregnant, including outreach and referral components.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Baby Blossoms and Omaha Healthy Start continue their activities. FIMR is in place in Douglas County. The TANF funded pilot project in Omaha completed its second year. When reissued as a competitive contract, an agency in Lexington, Nebraska was chosen. This project, in west central Nebraska, is focusing on new immigrant populations. Use of the Healthy Mothers, Healthy Babies helpline is being tracked.

The RFA for community-based MCH projects had a focus on life course approaches, including pre and interconception care. This focus is in accordance with a shift to earlier support of women and their husbands/partners, prior to pregancy. Women who are engaged in their care and receive supportive health information early will with some degree be more likely to seek prenatal care early when they do become pregant.

c. Plan for the Coming Year

A work group focused on infant mortality disparities did not get formed in FY 2008, as planned. This work group will be organized late in FY 2008 or early FY 2009. Extensive work has been completed in better understanding and addressing SIDS/SUID and preterm/low birth weight births as contributers to infant mortality among African Americans. The to-be-formed infant mortality work group will provide an opportunity to examine in detail issues such as access to and quality of prenatal care, newborn care, community and environmental factors, and other possible contributers to disparities.

State Performance Measure 9: *Hospitalization for unintentional injuries (per 1,000) for children and adolescents*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				110.4	110.2
Annual Indicator	122.2	111.7	117.5	118.6	
Numerator	57709	51706	55225	55890	
Denominator	472093	462820	469913	471382	
Is the Data Provisional or Final?				Final	
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	109.8	109.6	109.3	109	108.7

Notes - 2007
HDD will be available in October 2008.

Notes - 2006
HDD will be available in October 2007.

Notes - 2005
Hospital Discharge Data for 2005 is significantly under reported due to drop in hospitals reporting (82%).

a. Last Year's Accomplishments
This performance measure was previously part of a combined measure on intentional and unintentional childhood injuries. Separated in 2005 upon the completion of the comprehensive needs assessment, this measure now permits a better focus on the very diverse factors resulting in childhood injuries. As previously stated in this application and annual report, the Injury Prevention Program in Health Promotion Unit has provided leadership in injury prevention. That program has promoted Safe Kids Coalitions and proper child safety restraint use. See NPM #10 for information on injury prevention related to motor vehicle crashes.

Nebraska is ranked 47 out of 51 states when it comes to accidental injury deaths to children in the summer. Safe Kids Worldwide made available summer safety grants to those states that ranked the lowest, including Nebraska. The grants were awarded to state coalitions to develop a statewide summer safety awareness campaign in coordination with other local coalitions and chapters. The focus of Nebraska's campaign was home related drowning to children ages 1 to 4. The leading cause of death for this age group is drowning, with a total of 13 from 1999 to 2003.

This special initiative supplemened the ongoing work of the Injury Prevention Program and Nebraska Safe Kids.

In 2006, the program utilized the "Report on Unintentional Fall Related Injuries" released in 2005 to guide the development of a community-based initiative, "Fall Prevention for Children 14 and Under." With an allocation of Preventive Health and Health Services Block Grant funds, the Injury Prevention Program provided grants to Safe Kids Coalitions and Chapters across the state, which continued into 2007. Though small (about $1500 each), these local projects made progress in implementing local activities to prevent childhood falls. Activities are specific to age groups, such as playground safety for children ages 5 to 9 and sports/recreation safety for children ages 10 to 14.

Starting in 2006, one of the 8 community-based Title V funded projects focused exclusively on the prevention of household injury risks for children ages 0 to 4. Targeted to at risk pregnant women and families with young children, this in-home and clinic-based project serves about 750 families

per year.

The Child Death Review Team continued its work.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborated with Injury Prevention Program in promoting Safe Kids activities, such as child vehicle safety and fall-related injury prevention.			X	
2. Continued analysis of childhood injuries as part of Child Death Review Team.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Childhood fall prevention programs are still being implemented throughout the state by local Safe Kids chapters. With an allocation of Preventive Health and Health Services Block Grant funds, the Injury Prevention Program provided grants to Safe Kids Chapters across the state. Each grant was $2000, these local projects made progress in implementing local activities to prevent childhood falls. Four Corners Health Department's goal was to reach the community with safety education to prevent falls in children. The program consisted of two separate components, outdoor safety education and awareness building on last years bike safety theme (activity 1) and home safety education working with local daycare providers to provide safety information to families (activity 2).

Sarpy/Cass Department of Health and Wellness/Safe Kids chapter will be providing education, resources, and basic supplies to implement organized safe play in daycares, schools and preschool playgrounds. They will work to assess playgrounds and educate on safer play to caregivers and parents. Safe Kids Scottsbluff county will be purchasing baby gates and stationary play centers to help increase the community's awareness to the dangers small children face regarding falls in the home. They coordinate a yearly baby walker exchange program for stationery play centers and provide baby gates to low-income families at a low cost donation. They work with their head-start programs locally to coordinate the efforts.

c. Plan for the Coming Year

Continue to collaborate with Nebraska Safe Kids activities. The competitive RFA for community-based MCH projects did not include unintentional injuries as a focus, so will be increasingly depending on Safe Kids as the vehicle for childhood injury prevention.

State Performance Measure 10: *Hospitalization for intentional injuries (per 1,000) for children and adolescents (age 1-19)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007

Annual Performance Objective				5	4.9
Annual Indicator	4.4	4.1	3.9	4.1	
Numerator	2093	1908	1835	1917	
Denominator	472093	462820	469913	471382	
Is the Data Provisional or Final?				Final	
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4.8	4.7	4.6	4.5	4.4

Notes - 2007
HDD will be available in October, 2008.

Notes - 2006
HDD will be available in October, 2007.

Notes - 2005
Hospital Discharge Data for 2005 is significantly uinder reported due to drop in hospitals reporting (82%).

a. Last Year's Accomplishments
This performance measure had been previously combined with unintentional injuries. It became a separate measure upon the completion of the comprehensive needs assessment in 2005.

During 2006 LB 994 was passed, which included several provisions related to prevention and early detection/intervention of child abuse with a specific emphasis on shaken baby syndrome. Provisions include training requirements for licensed child care providers, inclusion of information in packet provided to newborn parents by HHSS/NE Dept. of Education titled "First Connections with Families - Learning Begins at Birth," parents viewing a video and written materials in health facilities prior to discharge of a newborn, and a public awareness campaign. Child Care Licensing, Lifespan Health Services, Protection and Safety, and Communications staff of DHHS worked on various aspects of these requirements. In addition, the Children's and Families Foundation lead an effort to develop and promote training and awareness of child abuse prevention/detection/referral among a wide range of early childhood care and education providers. These activities, begun in 2006, continued through FFY 2007.

The Title V/MCH Director actively participated in the Prevention Partnership, coordinated by the Children and Families Foundation. The Partnership began developing an action plan for implementing strategies from the Statewide Child Abuse Prevention Plan. Promotion of the plan through public engagement and the identification of best practices were priority actions for the year.

The appropriations bill passed by the Legislature and signed by the Governor included $600,000 per year for the next two years to expand home visitation as a child abuse and neglect prevention and early intervention strategy.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Completed implementation of shaken baby syndrome and child abuse prevention provisions of LB 994, including hospital based education and public awareness campaign.			X	
2. Continued collaborations with Protection and Safety and the Nebraska Children and Families Foundation to promote child abuse prevention materials, curriculum, and public awareness.			X	X
3. Collaborated with Protecion and Safety and Medicaid on guidelines for home visitation.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Work continued for implementing the shaken baby/sudden infant death provisions of LB 994. A contractor developed a video for hospital use, with accompanying written materials that address both topics. Currently in production is a Spanish language video.

The Prevention Partnership continues its work to implement the Statewide Child Abuse Prevention Plan.

Lifespan Health Services contributed to the development of a Request for Bids for home visitation as secondary prevention of child abuse and neglect. Contractors were selected this spring. These contracts, supported with State General Funds, are administered by the Division of Children and Family Services.

c. Plan for the Coming Year
Continue to support hospitals and child care providers in carrying out the abuse and neglect prevention provisions of LB 994. Continue to collaborate through the Prevention Partnership on abuse and neglect strategies.

E. Health Status Indicators

Overall the Health Status Indicators serve as useful tools in assessment, monitoring, and evaluating programmatic activities. The following narrative describes trends in Nebraska followed by a broader assessment of Nebraska's capacity to utilize these and other Title V indicators to direct public health efforts.

Low Birth Weight (LBW) and Very Low Birth Weight (VLBW)
#01A - The percent of live births weighing less than 2,500 grams.
#01B - The percent of live singleton births weighing less than 2,500 grams.
#02A -The percent of live births weighing less than 1,500 grams.
#02B - The percent of live singleton births weighing less than 1,500 grams.

LBW and VLBW babies are at greater risk of death within the first months of life and at increased risk for development of disabilities and illness throughout life. Nebraska Vital Statistics reports the low birth weight (LBW) rate from 1995 through 2005 varying between about 6.3 % and 7.2%, considerably above the Healthy People 2010 (HP2010) goal of 5.0%. Certainly disparities exist, most notably for African Americans (12.9% provisional 2005). The very low birth weight rate

(VLBW) in Nebraska traditionally remained at or below the HP2010 target of 9 per 1,000 live births for 25 years, but rose sharply above that level in the early 1990's. The rate has remained just at 13 per 1,000 live births (provisionally 14.2/1,000 in 2005) /2008/ provisionally 11.9/1,000 in 2006. //2008//over the last nine years. Again disparities, especially for African American infants (27.2/1,000 provisional 2005) are remarkable. Perhaps the most notable trends is the LBW for singleton births that continues to rise with every year up form 3.9% in 2001 to a provisional 5.2% in 2005/2008/ 5.3% in 2006 //2008//

/2009/a significant amount of work went into analyzing and developing theories of change and logic models over the past year (See attachment for section IIC Needs Assessment Summary). This work focused on singleton births and included prematurity as well. //2009//

These trends directly influenced Nebraska's State Priority # 3 (Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy) and will be utilized in evaluating Title V funded activities.

Fatal Injuries
#03A -The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.
#03B -The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.
#03C- The death rate per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes.

Injuries are the leading cause of death among persons aged 1 through 24 years and a significant health problem affecting Nebraska's children. The provisional data for 2005 indicates that overall the child death rate is down. Certainly child death rates due to motor vehicle accidents (leading cause) are on a downward trend since 2001 while observed child restraint usage as reported by the Nebraska Occupant Protection Usage Survey is up from 67% in 2001 to 88% in 2004. Unfortunately, Nebraska Department of Roads reports that alcohol use in crashes where children were killed increased from 1995 to 2001 and has remained stable since then (20%). Nebraska's Child Death Review Team reports that the most common cause of non-motor vehicle-related, unintentional death is drowning which is most prevalent among children under age 11.

Nebraska has one priority need addressing unintentional deaths. State Priority # 4 Reduce the rates of hospitalizations and deaths due to unintentional injuries for children and youth.

Non-Fatal Injuries
#04A - The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.
#04B - The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.
#04C - The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Data for 2005 is unavailable at this time and as discussed previously the 2004 Hospital Discharge Data experienced a significant decrease in reporting likely resulting in inaccurate (under) estimates. However, the Nebraska Department of Roads reports that total motor vehicle car crashes and injuries are declining and that restraint use is up due in large part to the mandatory seat belt law affected in 1993. Nebraska Safe KIDS reports that the number one case of unintentional injury and hospitalization to children is falls.
/2008/ Hospital discharge and injury data in Nebraska is still experiencing reporting problems. 2005 data is thought to be under reported and inaccurate.//2008//
/2009/ Non-fatal injuries due to motor vehicle crashes appear to be declining (4b & 4c) although Hospital Discharge Data is still experiencing reporting issues. //2009//

Nebraska has one priority need addressing non-fatal unintentional injury. State Priority # 4

Reduce the rates of hospitalizations and deaths due to unintentional injuries for children and youth.

Chlamydia
#05A The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.
#05B The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia

Infections due to chlamydia are the most commonly reported notifiable disease in Nebraska. According to Nebraska Communicable Disease Surveillance, Nebraska women of child bearing age have chlamydia infection rates that have been increasing at statistically significant rates since 1995 while racial and ethnic disparities exist.

In 2004, 5,214 chlamydial infections were reported in Nebraska a rate of 301.3/100,000; female rate of 436.0. The higher rate for females is thought to reflect the larger number screened (20% identified in family planning clinics, in 2004). The chlamydia cases for 15-19 years of age were 32 % of the total, while women age 20-24 represented 36.4 % of the total. Disparities exist; in 2004 the Caucasian rate of 187.5/100,000 is compared to the African American rate of 2497.8 and Hispanic rate of 602.3.
/2008/ In 2005, a small decrease in infections was reported (5,080) in Nebraska a rate of 290.7/100,000; female rate of 418.6. The higher rate for females is thought to reflect the larger number screened. The chlamydia cases for 15-19 years of age increase representing 36 % of the total, while women age 20-24 represented 40.5 % (increase) of the total. Disparities exist; in 2005 the Caucasian rate of 182.7/100,000 is compared to the African American rate of 2467.4 and Hispanic rate of 514.3(decrease). The highest rates occur in Douglas County (514.3/100,000).//2008//

Discussion
The annual reporting of the Title V/MCH Block Grant performance/outcome measures, health systems capacity indicators, and health status indicators are the responsibility of the SSDI Director who collects and analyzes data provided by several managers and analysts across NHHSS. To date this has been an exercise conducted with little utility, because the goal is to complete the annual report, and not conduct program or policy development/evaluation. Due to the extensive list of NPM, SPM, HSCI, and HSI only the epidemiology staff has the time and capacity to monitor and internalize all of the indicators restricting the usefulness for practical applications.

Another issue regarding the utilization of health indicators that has emerged over the past year is the relationship between Nebraska Health and Human Services System and the relatively new local health districts. Nebraska's Title V/MCH funds have been involved in building MCH capacity among the public health districts that formed in 2000/2001. This includes funding local MCH assessments to be conducted over the next two funding years (07-08) that will feed into the next five year assessment due in 2010. This activity has prompted a new level of collaboration around data, indicators, and methodology (especially standardizing assessments) and goes much farther and deeper than the MCH population.

This new relationship around data has underscored the importance of choosing a reasonable number of indicators and measures that are meaningful and manageable at both the state and local level. In a relatively small state manpower must be prudently focused in monitoring health needs.

Clearly there is a need to disseminate data analysis and trends to state program managers/policy makers and local communities and as the MCH Epidemiology program grows this need is becoming a priority. To address this, the MCH EPI Unit through the SSDI grant plans to lead an effort to produce an annual MCH and CSCHN surveillance report(s) as a mechanism to disseminate information about the States MCH population and direct public health efforts. The report has two functions: 1) gain buy-in and participation of state program mangers in the utility

and function of monitoring MCH health indicators, 2) provide useful data analysis to local agencies and other MCH stakeholders.

/2008/ Work with the Local Health Departments has progressed and capacity to understand and utilize health indicators has grown. The issue of what indicators are most useful and how many should be utilized in local assessments has not been determined by the community. Limitations which were evident in the last application like manpower will continue to be an issue, but more pressing issues such as educating local public health professional about Maternal and Child Health, about assessment, and even indicators has underscored just how much work needs to be done. While work on an annual MCH and CSCHN report has not begun it remains in the SSDI plan.//2008//

/2009/ One product of DHHS reorganization is the five priorities of the Chief Medical Officer and Director of the Division of Public Health of which one is to become the trusted source of state health data. This will require quality improvements to some of the DHHS datasets as well as a reliable consistent report to the public and data users. The SSDI Director will provide leadership in the area of Maternal and Child Health data and indicators. In addition, the SSDI Director will be preparing internal staff over the next funding year for the 2010 Needs Assessment, this will look closely at the Health Status Indicators.//2009//

F. Other Program Activities

The Perinatal, Child and Adolescent Health (PCAH) Program, within Lifespan Health Services, continues to contract with Nebraska Methodist Hospital to provide the Healthy Mothers/Healthy Babies Helpline, Nebraska's toll-free telephone line, as required by statute. The PCAH Program Manager is the state-level contact person for the helpline. The HMHB Helpline provides 24-hour nurse-operator service to the MCH population statewide regarding health care questions, and information and referral for the following: Title V and Title XIX providers, Kids Connection, newborn screening disorder-specific information, and folic acid supplementation. Monthly call report data are tracked and analyzed in order to guide publicity efforts. When the line first began in 1992, calls averaged 7 per month. Call frequency peaked at 880 in FY 2000 with a steady decrease to 415 for FY 2004. Year-to-date in FY 2005, there have been 214 calls to the Helpline. PCAH staff has been assigned to analyze the data to identify reasons for the downward trend in usage, to research how other states promote their helplines, and to organize a committee to develop a marketing plan to promote the Nebraska Helpline. PCAH and MCH Planning & Support staff will continue to collaborate to take measures to increase use of the HMHB Helpline in FY 2006.

/2008/ The HMHB brochures, posters, and magnets have been redesigned. Brochures are available in English and Spanish. The Community Health Nurse III sent a cover letter and sample materials to over 2,300 Nebraska physicians, nurses, health departments, and agencies to promote the helpline. Other promotion efforts included a HMHB webpage and a presentation to WIC agency directors. The HMHB helpline number is listed in the community service pages of local telephone books, and an ad was placed in the Journal-Start Baby Steps publication which reaches families in southeastern Nebraska. To date, over 11,000 brochures have been sent to clinics and agencies. Calls continued to decline in FFY06, however, with recent promotion efforts they are increasing for FFY07. There were 207 year-to-date in FFY07 compared to 136 during this same time period in FFY06. The helpline is also being promoted through the Nebraska Perinatal Depression Project website, brochures, posters, and exhibit. HMHB call staff received one hour of training on perinatal depression earlier this year. The CHNIII will continue to monitor call reports and promote the use of the helpline. //2008//

/2009/The HMHB line received 306 calls during FFY08. To promote the helpline, posters, brochures, magnets and table tents were designed and distributed to health providers,

local health departments and agencies across the state. During FFY07, 393 posters, 13,309 English brochures, 4,275 Spanish brochures, 8,288 magnets and 201 table tents were sent out. The HMHB number appears in "blue pages" in phone books across the state, and a webpage describing these services appears on the DHHS website. The phone number is also promoted in the perinatal depression public awareness consumer resources.//2009//

Title V funds have supported a variety of public health infrastructure developments for some time. Nebraska has been recognized nationally for its great strides in recent years to develop statewide local health departments with tobacco settlement funds. In the previous three years, a portion of Title V funds were set aside for subgranting with the local health departments eligible to receive Tobacco Settlement funds. An MCH capacity-building focus continues with the LB 692 recognized health departments. The funding mechanism with local health departments shifts to contracts from subgrants and the level of Title V funds for MCH community-level infrastructure increases in FY 2006. Contract negotiations with individual health departments will take into account the current infrastructure level and an assessment of the capacity-building activities needed to continue a steady expansion alongside the tobacco settlement investment. As for other community-based organizations, a requirement for receipt of Title V funds is that these organizations communicate their service plans with their local health department and identify if sufficient capacity exists to support its plan. Title V also continues to support infrastructure at the state-level by internal allocations to 14 programs/administrative units.

Staff of MCH Planning & Support provided technical assistance in Program Development (logic model). Conducted by Ron Mirr, M.S.W., the workshops were held in November 2004 in Columbus and North Platte. In collaboration with the Office of Minority Health, the two-day training was repeated in Lincoln in May 2005 for Native American communities. Process evaluations were highly favorable from participants at each of the three sites. An outcome evaluation indicated that the majority have used skills in the six months post-training.

/2007/ Logic model planning was required for the community-based subgrant applications. Eight community-based organizations and the four federally-recognized Native American Tribes headquartered in Nebraska were awarded funds for the three-year funding period FY2006-2008. Subrecipients report quarterly by providing updates to their logic model workplans, and provide data on performance measures by the final report. //2007//

A primary role of MCH Planning & Support is subrecipient monitoring, as required by the Office of Management and Budget (OMB), and described in the OMB Circulars. As part of NHHS single-agency audit, Title V/MCH has been diligent in its efforts to clear an earmarking audit finding. NHHS with the assistance of MCH Planning & Support has submitted public comment to OMB by suggesting changes to the OMB A-133 Compliance Supplement. The recommendations, if incorporated by OMB, would assist auditors in the correct interpretation of the Title V earmarking requirement. The unresolved audit finding on earmarking puts Nebraska at risk of paying back any questioned costs, which NHHS maintains is unknown due to the incongruent forms, instructions, and audit guidance approved by OMB.

/2007/ Nebraska again suggested changes to the OMB A-133 Compliance Supplement, and to the MCH/Title V Guidance and Forms, OMB #0915-0172, including the financial reporting forms. None of the recommendations were incorporated, so the audit finding is unresolved. //2007//

In FY 2004, MCH Planning & Support worked with the University of Nebraska--Lincoln (UNL) Bureau of Sociological Research to negotiate "social capital" questions on their annual statewide phone survey. The Bureau has conducted the Nebraska Annual Social Indicator Survey (NASIS) for over 25 years, but had not previously selected questions of this nature. The Bureau added seven core questions on the Fall 2004 NASIS to establish a baseline. Results will help guide activities to increase civic participation, as a correlate to public health, and identify methods for public input on the Title V plan.

/2007/ A Social Capital report prepared in 2006 will be utilized in planning. //2007//

Using models identified in a report commissioned with the University of Nebraska Public Policy Center, the Office of Family Health will be the catalyst for a Nebraska-based "virtual MCH institute" if sufficient implementation funds are identified. The institute will be responsible for creating and maintaining MCH capacity with collaborative partners at individual, community, and statewide levels.

G. Technical Assistance

With the five-year comprehensive needs assessment completed earlier this year, focused attention must now be given to strategy development. For many of the ten identified priority needs, programmatic and system level planning processes are underway, which the Offices of Family Health and Home and Community Based Services for Aged and Physically Disabled will engage in and utilize for determining mid and long term strategies. For instance, the Nebraska Cardiovascular Health Program published earlier this year a plan for nutrition and physical activity. This plan will guide the selection and implementation of strategies to address overweight among women, children and adolescents. Similarly, HHS Protection and Safety has begun development of a child abuse prevention plan, and will be collaborating with the Office of Family Health in its preparation.

As described in the needs assessment, specific attention was given to assessing MCH capacity to carry out the ten essential public health services, using the CAST-5 tool. Subsequently, the Office of Public Health led the assessment of the State Public Health System using the National Public Health Performance Standards. This latter process will be used to develop a new Nebraska Public Health Strategic Plan. With the wealth of information derived from these parallel, complementary processes, Nebraska is in an excellent position to create a strategic plan crafted specifically for MCH infrastructure capacity building. To do so, though, technical assistance is needed on bridging the two assessment processes and linking State Public Health System Planning with MCH capacity building planning.

Nebraska is therefore requesting technical assistance to design next steps in a MCH strategic planning process. Possible sources of the technical assistance would be the Women's and Children's Health Policy Center or the Oregon Office of Family Health. Specific assistance needed would be: means for doing a cross-walk between the two previously completed assessments; recommendations on any follow-up/targeted assessment; and a process for moving from the assessment findings to an integrated State Public Health/MCH strategic plan.

/2007/ During 2006, a number of related planning activities have occurred that impact next steps for MCH/CSHCN strategic planning. Well underway is a comprehensive state level planning process to update Nebraska's Turning Point Plan. The updated plan will provide strategic direction for Nebraska's public health system for the next five years. Secondly, operational planning is occurring jointly between Health and Human Services Regulation and Licensure and Nebraska's local health districts, to map out infrastructure and capacity needs and relative responsibilities for the next ten years. Finally, the MCHB planning workshop offered in Kansas City in June provided useful background in MCH specific planning strategies.

Nebraska continues to need and is requesting technical assistance in designing next steps in MCH strategic planning. The preferred source of technical assistance is the Family Health Outcomes Project in California, specifically Judith Belfiori and Gerry Oliva. Their consultation to our needs assessment process was valuable and forms a strong foundation for next steps in planning. Their prior experience with our state and stakeholders will place them in a good position to provide effective consultation and facilitation. //2007//

/2008/ Late in FY 2006, Nebraska Title V/MCH and CSHCN obtained the consultant services of

Judith Belfiori and Gerry Oliva, using existing resources to finance the consultation. The strategic planning process is now underway.//2008//

/2009/Nebraska Title V/CSHCN is requesting that the Maternal & Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA) provide consultation to assist with the development of a transition program for youth with special health care needs to transition into adulthood in the areas such as employment, medical services, home and community support to enable them to live independently and participate as members of the community. //2009//

V. Budget Narrative

A. Expenditures

Nebraska has longstanding concerns with the budget and expenditure forms and instructions. Subsequently, the narrative in Sections V. A & V. B remains much the same as in the past two years. Our concerns stem from incongruent requirements of an annual report for a grant with a two-year period of availability of funds. Despite our best efforts to clarify and communicate concerns over time, to-date we believe these attempts have failed to be understood. We submitted written comments and recommended changes to Federal entities involved in the review, revisions, and re-approval of the Guidance and Forms in May 2003, although no significant revisions were made to the financial portion of the Guidance and Forms. As a result, this narrative attempts to re-clarify the limitations of the financial forms, as much to justify expenditures of Nebraska's Title V funds for FY 2004.

Our longstanding concerns were heightened for FY 2000 and FY 2001. Audits of those years resulted in Federal findings that Nebraska was not in compliance with the statutory earmarking requirements. The corrective action plan to resolve the finding was an extensive commitment of Title V administrative staff time, in consultation with a respected authority on federal policies affecting acquisition, administration and audit of Federal grants. We continue to strive for audit resolution for Nebraska, and we believe ultimately to improve the utility of the information while minimizing the reporting burden to all states.

The period of availability of the Federal MCH allotment allows expenditures in the fiscal year or the succeeding one, i.e. a two-year period (42 U.S.C. 703(b)). For example, the FY 2004 report should include expenditures of the allotment that can occur during the period October 1, 2003 - through September 30, 2005, although that is 21/2 months beyond the FY 2004 report due date of July 15.

The instructions for the annual report's financial forms are vague and contradictory. Form 3 instructions state: "columns labeled *expended* are to contain the actual amounts expended for the *applicable year*." (Emphasis added). *Applicable year* is not defined in the Glossary. Form 3 feeds into sequentially numbered forms, even further confusing the instructions for Form 4 and Form 5, stated: "enter the budgeted and expended amounts for the appropriate *fiscal year*." (Emphasis added). *Fiscal Year* is not defined either, although is generally understood to mean a 12-month period for accounting purposes, with a caveat that *Fiscal Year* is a 24-month period for an allotment with a two-year period of availability of funds. Without clear guidance, Nebraska opted to report expenditures "during" FY 2004 (October 1, 2003 - September 30, 2004), a combination of the FY 2003 and FY 2004 allotments. The attached table depicts the overlap of the two-year period of availability of funds with the fiscal year period, relative to the reporting due date. The shaded cells show the context of the expenditures submitted with this report.

/2007/ The shaded cells in the revised Table 1 highlight the problem with the financial reporting requirement in the *annual* report to show compliance with the earmark requirement of an allotment with a *two-year period of funding availability and carry-over authority*. //2007//

Section 506(a)(1) of Title V, Social Security Act [42 U.S.C. 706] states generally the requirement for submitting an annual report. Section 506(a)(3)(E)(b)(1) states that expenditures from amounts received under Title V are to be audited not less than once every two years. The two-year audit period may have been intended to coincide with the period of availability of funds for the Federal allotment. Financial forms re-approved in May 2003 for the Block Grant Guidance & Forms, as part of the required annual report, are not designed for an audit of the two-year period in which an allotment can be expended. This audit limitation is especially critical for the earmarking requirement established in statute. To further confuse the requirement, the terms "payment" and "allotment" are used interchangeably in statute. [Section 705(a)]. Taken together, the provisions

for earmarking and the period of availability of funds make a convincing case that the earmark must be met over the period for availability of funds, not over the single fiscal year in which funds are expended.

There is one especially bothersome aspect of the audit finding, and so the reason for our persistent approach to make clear the problems with the financial forms. The audit finding proposed questioned costs of $96,000 for the FY 2000 audit because the auditor was unable to determine if the State met the expenditure requirement for at least 30% for preventive and primary care services for children. In our response to the proposed finding, we successfully argued that the questioned costs were unknown because the annual report did not require reporting expenditures of the allotment. A year later, without audit resolution, the auditors expanded the finding to include all the earmarks (30-30-10) through a scope limitation. (Note: Nebraska's audit findings are the result of the auditors' inability to test records, nor due to our withholding information or preventing testing.) To-date we have not been required to pay back funds, however, until there is resolution, the finding remains.

Financial reporting in the FY 2004 Report, as in prior years, conforms to the required annual report format showing funds expended in a fiscal year. FY 2004 will be audited in August 2005. The table attached illustrates the incongruent requirements, causing the Federal audit finding for earmarking for three consecutive years, to date.

One possible solution is to maintain two separate record keeping systems, one for the required annual report based on fiscal year payments and another by expenditures of the allotment. Separate record keeping would be unnecessary if the annual reporting forms were revised to reflect the two-year expenditure of an allotment by subcategories of "Types of Individuals" and "Types of Services". Presently, accounting staff assigns codes to distinguish individual expenditures by allotment within a fiscal year. Additional coding could identify earmarked expenditures of an allotment across the two-year period of availability of funds. Pairing allotment with earmark coding would eliminate the need to keep two separate systems to be compliant with auditing and to continue submitting annual reports in the format prescribed by MCHB.

/2007/ It would be inefficient and burdensome to comply with both the annual reporting requirement and a separate accounting for earmarking on the two-year allotment. As part of the clearance review process of the Paperwork Reduction Act, Nebraska again submitted comments and specific recommendations for revisions to the Guidance and Forms that would improve the utility of information and minimize the reporting burden for all respondents, i.e. it impacts all states and territories. None of Nebraska's recommendations were incorporated and therefore the longstanding earmark audit finding continues unresolved. //2007//

The local community subrecipients are monitored by line item budgets and expenditures to achieve the detail and accuracy to monitor Federal funds. Since subrecipient monitoring is also a compliance requirement, it is not an option to minimize reporting by scaling down those reports and only reporting the earmarked, subcategory expenditures. Although somewhat cumbersome to have subrecipients report both by line item and by category expenditures, this appears to be more feasible than to report one way to MCHB and to maintain another method to achieve audit compliance. We have urged that these data elements be reduced to the absolute minimum needed to allow for compliance with the statute authorizing the MCH Block Grant, i.e. the earmarked 30-30-10. Further, we have suggested that the fiscal data required by Section 706(a)(2)(iv) be combined with the requirement and timing for submission of the reporting required under 45 C.F.R. 96.30(b), i.e. OMB Standard Form 269A "Financial Status Report" (FSR). This would enhance the ability of all states to reconcile periodic financial reports submitted to the Federal government with their annual financial statements audited pursuant to OMB Circular A-133. Further, it would create the ability to demonstrate states' current carry-over authority available under Section 703(b) of the statute.

Without the additional accounting records of expenditures by allotment and earmarking, the

auditors relied on the annual report (Form 4) to test if the earmarking requirement was met. Form 4 has two limitations to use it for auditing compliance: 1) expenditures are based on the fiscal year (not the expenditures of an allotment); and, 2) the expenditure column of Form 4 "Types of Individuals" combines the Federal expenditures with expenditures of State match ("Federal-State Partnership"), although earmarking is based on the Federal allocation only. 42 U.S.C. 706(a)(2)(iv). (See also, Legislative Briefing Title V Law Legal Compendium, New MCH State Leaders' Orientation Manual, October 2000, pg. 19). In other words, Form 4 does not identify earmarking expenditures because it is a combination of Federal and State funds, nor does it make the necessary distinction between expenditure of an allotment and expenditures in a fiscal year.

The FSR reflects the obligations and expenditures for the period of availability of funds, although the format does not incorporate the requirement to categorize expenditures by "Types of Individuals" (Form 4), nor "Types of Services" (Form 5), as required by U.S.C. 706(a)(2)(iv). The non-final FSR (due 15 months into and 9 months prior to the conclusion of the period of availability of funds) seeks obligation of unexpended funds for carry-over authority. The FSR is critical to the Form 2 budget and subsequently the remainder of the financial forms driven by it.

Budget-to-expenditure variations (Forms 3, 4, and 5) cannot be explained without discussing Form 2, albeit a budget form in a section to explain expenditures. Specifically, Line 2, Form 2 "Unobligated Balance" is problematic due to misinterpretation of several lines of the FSR, i.e. "Unobligated Balance" and "Unliquidated Obligations," which are similar phrases, but with a distinct difference for budgeting. The FSR seeks the "Unliquidated Obligations," i.e. obligated funds not yet expended. In a non-final FSR, Nebraska calculates "Unliquidated Obligations" as allotment minus outlay. In the final FSR, the same line must be zero. As stated on page 57 of the Block Grant Guidance & Forms, the MCHB instruction overrides the standard instruction for Standard Form 424, Line 15b. ("Applicant") by instructing applicants to report the "Unobligated Balance." That figure feeds Line 2, Form 2. If Form 2 sought the "Unliquidated Obligations" (obligated, unexpended funds) rather than the "Unobligated Balance", the budget would accurately reflect the new allotment plus the carryover from the previous allotment. Accordingly, the definition for "carryover" in the glossary should be revised. Since Nebraska reports zero "Unobligated Balance", our budget reflects only the new allotment. The difference is typically six figures. Nebraska exercises carry-over authority, although is unable to budget carry-over using the present form and instructions, so its grant expenditures exceed budget. A wide variance between budget and expenditures as with previous years, is explained primarily by the incompatible budget and expenditure reporting formats originating with the misinterpretation of the FSR, which feeds Form 2, Form 3, Form 4, and Form 5.

Form 4 requires that administrative costs be reported along with categories of "Types of Individuals". The staff responsible for the administration of Nebraska's MCH Block Grant do not provide services, although administrative costs must be reported among "Types of Individuals Served." Including administrative costs with expenditures for services detracts from the percentage for 30-30 earmarked expenditures could contribute to auditing irregularities. Administrative costs would be more logically and accurately reported on Form 5 as part of the subcategory "Infrastructure." Administrative functions contribute to state-level MCH infrastructure by needs assessment, planning, policy development, monitoring, building information systems, etc.

/2007/ References to specific years are not updated within the text of the original submission in July 2005, although the previous narrative remains valid in all other respects. //2007//

/2008/ Despite the extreme inefficiency and burden to maintain two separate record keeping systems, Nebraska is doing so to clear a longstanding unresolved federal audit finding on earmarking. One record is kept based on fiscal year payments to satisfy the annual report requirement. A second system was created to be auditable for the statutory earmark expenditures of an allotment (with a two-year period of availability). The second record is being

implemented in two steps, i.e. Part I and II. (Note: Because it uses a retrospective methodology, Part I relating to the 2006 grant will actually occur after the completion of Part II relating to the 2007 grant.) Part II: A coding methodology was developed and prospectively implemented for the 2007 grant to record expenditures of earmark categories by grant. The timeline for completion of Part II was March 1, 2007 and was completed in June 2007. The new coding procedures are in effect beginning July 1, 2007. Coding by types of individuals was added to the codes by allotment to capture the earmark expenditures over the two-year period of availability. Expenditures by earmark categories will be calculated for the 2006 grant using a retrospective methodology. The expenditures by earmarked categories, as reported by subrecipients, internal allocated units, and contractors in FY2006 and FY2007, will be applied to payment history for the 2006 grant. The timeline for completion is December 31, 2007. //2008//

/2009/ The accounting code procedures to identify the expenditures by types of individuals has been in effect for one year and will continue as established. The first cycle for coding expenditures within an allotment is expected to be complete in approximately March - April 2009 when the FY 2008 federal allotment will be fully expended.//2009//

B. Budget

Much of what is requested for budget narrative has already been described in the Expenditure narrative, although in it budget features are addressed and clarified as they relate to expenditures. Our determination to make a shift in the context is due to the inextricable relationship of budget and expenditure, and our interpretation that statutory "maintenance of effort" and "earmarking" requirements are based on expenditures. The guidance and forms mistakenly connects these to budget. The Guidance for Section V. "Budget Narrative" confuses these distinctions by instructing the expenditure narrative to precede budget narrative. Logically, expenditures are "subsequent to" budget. Heading Section V. "Financial Narrative" would be more descriptive of the section content as it would be inclusive of budget and expenditures.

Budget and expenditures are necessarily intertwined. Understanding the particular function of budget and expenditure are important for accountability, as the use of funds is based in statutory requirements. It is not the intent to minimize the purpose of budgeting, although we believe it is responsible to emphasize our understanding that accountability is entirely related to expenditures. Expenditures, of course, are legitimized by a realistic budget.

An introductory statement in the budget Form 2 instruction states: "This form provides details of the State's MCH budget and *the fulfillment of certain spending requirements* under Title V for a given year." (Emphasis added.) Contrast budget as a plan for expenditures with actuality being the expenditure of funds. The fulfillment of spending requirements, i.e. "earmarking" and "maintenance of effort", comes with expenditure; it is not a direct result of budget alone. If compliance of earmarking and maintenance of effort were based in budget, although they are not, Form 2 would be further misleading. Due to its limitation to budget carryover (see Expenditure narrative for detail), the earmarkings are percentages of the budgeted allotment, rather than the allotment plus carryover.

Amount, source, and time period are critical components in budget and expenditure. Form 2 seeks a budget overview of funds, including "Other Federal Funds" under the control of the person responsible for the administration of Title V. The format does not allow for subsequent report of actual expenditures of the budget amount of "Other Federal Funds." Further, some of these other Federal funds do not mirror the Title V fiscal year period of October 1-September 30, making it difficult to accurately understand the financial relationships between the various sources and amounts of funds to Title V.

Federal Title V support clearly complements Nebraska's effort. Nebraska's budgeted "maintenance of effort", based on FY 1989 State support, has consistently been surpassed. The source of non-Federal funds is a combination of State Comprehensive Systems and local funds

and in-kind support to meet both maintenance of effort and the 3:4 match requirement. The largest single source of State support comes thru the Medically Handicapped Children's Program (MHCP). Other sources of State funds that complement Title V funding include support to the following programs: the Immunization Program for vaccine purchase, Newborn Metabolic Screening Program which also includes a cash fund from screening fees, Reproductive Health Program, and Birth Defects Prevention legislation to support genetic clinics at the University of Nebraska Medical Center.

The inadequacies of the financial forms to produce meaningful and accountable information is further demonstrated between Form 2, Form 3 and Form 4. Compliance with the 30-30-10% earmarkings is suggested on Form 2 budget, although we interpret the statutory earmarking requirements as the expenditure of allotment. The expenditure of the Federal allocation (Form 3) is shown separate from the earmarked categories of expenditures on Form 4, which are a combination of Federal and State funds. Form 4 cannot be used to determine earmarking compliance, as that is based on the Federal allotment alone. Form 5 is also plagued with similiar problems as Form 4, although not in the same statutory compliance since the Form 5 categories are not earmarked. (See Expenditure narrative regarding Form 5 relative to administrative cost and infrastructure.) If administrative costs were incorporated on Form 5, as suggested, Form 5 would need to identify the distinction between budget for Federal and State funds relative to the 10% earmark. We have previously asked on multiple occasions to have a clearer definition of "administrative costs," None of these requests for clarification have been satisfied.

Any significant year-to-year budget variations are difficult to discern, and subsequently to explain, in the present format and instruction limitations to these financial forms.

/2007/ The budget narrative submitted July 2005 remains unchanged. //2007//

/2008/ The budget narrative submitted July 2005 and July 2006 remains unchanged. //2008//

/2009/ The budget narrative submitted July 2005, July 2006, and July 2007 remains unchanged. //2009//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.